Coordination of Services to Children and Youth in Newfoundland & Labrador

Individual Support Services Plans

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(Revised)

Dept. of Education
Dept. of Health
Dept. of Human Resources & Employment
Dept. of Justice

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Introduction

The purpose of the first part of this document is to describe the process involved in developing an Individual Support Services Plan **(ISSP)** in order to assist all agencies and service providers collaborate with parents/caregivers, children/youth and/or each other when one or more agency is involved with a child, regardless of the child's setting. The overall purpose of the ISSP process is to ensure continuity of service at all developmental stages in a child's/youth's life.

The remaining parts of the document address issues regarding writing an Individual Support Services Plan (**ISSP**) for a child/youth. The latter sections address the ISSP process for multiple settings, recognizing that the plan must reflect collaboration with individuals when and if they are providing consultative or direct services to a child/youth. This is necessary to enhance each service providers efforts, particularly when programs and services are being provided by more than one Division of an agency/department or multiple agencies. Otherwise, players might be working at cross-purposes ----- and vice versa.

This document acknowledges the principles of the Model for Coordination of Services to Children and Youth with Special Needs in Newfoundland and Labrador, endorsed in the Classroom Issues Report (June, 1995) by the Departments of Education, Health, Social Services and Justice, Newfoundland and Labrador Teacher's Association and the Newfoundland and Labrador School Boards Association. This document also acknowledges that a support services planning process is a process utilized by many service providers in the development of Individual Support Services Plans. For example, in Social Services, as is known, a General Service Plan (GSP), in Health as a Treatment/Care Plan and Education , the term Individual Program Plan (IPP) or Individual Support Plan (ISP) is used.

For the purpose of this document, the term "child" will refer to any child/youth/ student. Also the term "parent" refers to parent(s) and or guardian(s). "Goals" refer to "outcomes" and "objectives" to "keystage outcomes".

To complete the child/youth profile referred to in this document the team will need to refer to the document "Profiling the Needs of Children/Youth in Newfoundland and Labrador

Section One

The Process:
Individual Support Services Plan

The Individual Support Services Planning Process

This section is adapted from the Model for the Coordination of Services to Children and Youth With Special Needs in Newfoundland and Labrador draft (Departments of Education, Health, Social Services and Justice, 1996).

The individual support services planning process is a method used to identify the child's/youths strengths and needs and to prepare an integrated approach to meet those needs. It is meant to be a collaborative process involving the child, the parent and service providers including School Personnel, personnel from the Departments of Health, Human Resources and Employment, Justice and other relevant agencies working together to identify appropriate goals for the child/youth and the approaches to achieve those goals. The strengths, needs and goals which are defined by this process are recorded, and this record is called an Individual Support Services Plan.

An Individual Support Services Plan (ISSP) is a summary of relevant information regarding the child and the program which will be followed. It generally includes the materials, equipment, relevant health information (eg. allergies),strengths, needs, goals (home, community, preschool and/or school), and other relevant supports and services identified for the child as a result of the ISSP process. It is also used as a long-term planning tool and over time becomes a record of the child's accomplishments. In this regard, the ISSP is one of the most important records kept for an individual child.

The ISSP is a working document and as such should not contain background information or confidential facts which are not relevant to the supports required throughout the life of the plan.

The process described in this document, and in the Model for the Coordination of Services to Children and Youth With Special Needs in Newfoundland and Labrador (Departments of Education, Health, Social Services and Justice, 1996), is the process which you are familiar with at present and incorporates the same key components currently utilized by your agency/partners in their own settings.

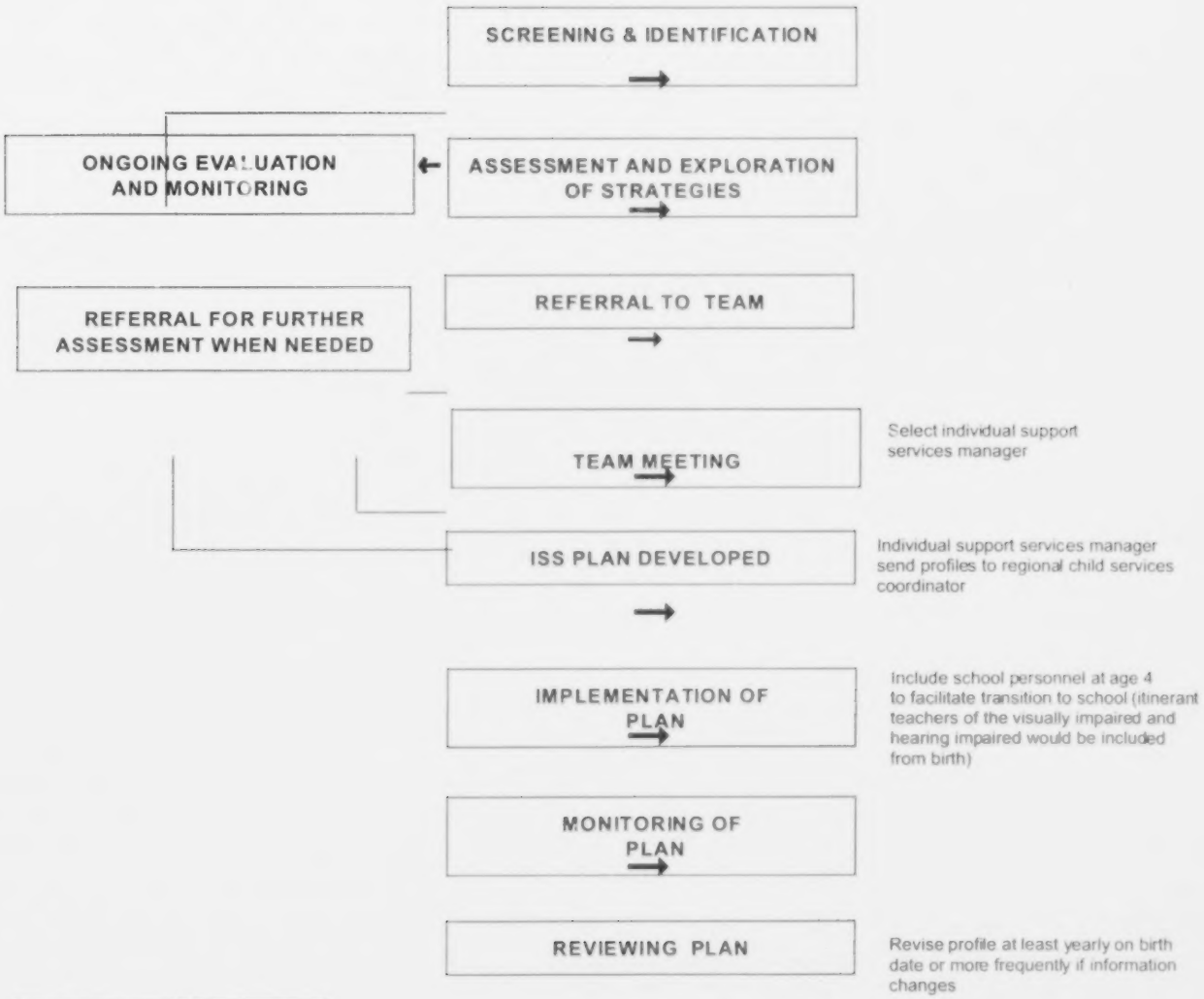
The objectives of the individual support services planning process in any setting are to:

- ensure that the relevant contributions of each service provider to the plan reflect a holistic child centered approach;
- ensure that the child and family are full partners in the planning process;
- ensure that service planning reflects the sharing of knowledge and expertise among the service providers;
- ensure continuity of service provision, reduce fragmentation and duplication of resources;
- ensure a common format to service planning, which does not preclude the unique contributions that each provider may bring to the plan.

While the ISSP process adheres to a certain format, the needs of the child and his/her family determine the planning approach, in practice, taken in any setting. The process must be flexible in terms of the level of formality and the format used. A child with more complex needs for instance may require a greater number of service providers and a greater need to ensure effective communication, information-sharing and consistent service delivery.

The steps in the ISSP process are illustrated in the following diagram (Figure 1). This diagram indicates a series of activities that may already be taking place in terms of service(s) to the child, even if these activities are not formally labeled "support services planning". In many situations service providers are already collaborating around a child's needs, in partnership with the child and family. The purpose of this diagram is to lend clarity to the process, ensuring that decision-making occurs at the local level and results in desirable outcomes for the child in a planned and effective manner.

THE INDIVIDUAL SUPPORT SERVICES PLAN: THE PROCESS


SCREENING & IDENTIFICATION
ONGOING EVALUATION AND MONITORING
ASSESSMENT AND EXPLORATION OF STRATEGIES
REFERRAL FOR FURTHER ASSESSMENT WHEN NEEDED
REFERRAL TO TEAM
TEAM MEETING
Select individual support services manager
ISS PLAN DEVELOPED
Individual support services manager send profiles to regional child services coordinator
IMPLEMENTATION OF PLAN
Include school personnel at age 4 to facilitate transition to school (itinerant teachers of the visually impaired and hearing impaired would be included from birth)
MONITORING OF PLAN
REVIEWING PLAN
Revise profile at least yearly on birth date or more frequently if information changes

Membership:
child
parent(s)/guardian(s)
Health personnel
Human Resources & Employment personnel
Education personnel
other agency representatives
Justice personnel

Figure 1

The Individual Support Services Planning Team

The role and function of the Individual Support Services

planning team is to ensure that service providers in conjunction with the child and family collaborate on the development of a common support services plan. The support services planning document reflects the agreed upon contributions of all team members to meet the child's identified needs.

While the composition of the team will always be determined by the nature and complexity of the child's needs, whenever possible the number of team members should be kept to the minimum. Streamlining the process is not meant to compromise service quality or the contribution of any service provider. During initial or other subsequent team meetings it may be necessary to involve multiple service providers, from your or other agencies, to ensure the range of issues are identified and addressed. Again the determining factor should be the child's needs.

The team is composed of...

* the child
* parents/guardians
* service providers (see Note)
* other relevant players.

Note: *where there is more than one professional from an agency serving the child,* each agency could, if deemed appropriate, designate a single transdisciplinary representative as a team member or agency spokesperson; this could be the individual who is already designated as the liaison for the child within that agency; where this occurs, the following are the responsibilities of the agency representative/team member:

* coordinate/consolidate the response of all professionals within their agency/department
* communicate proposed plan among agency's professionals; negotiate agreement; obtain decisions
* sign plan as designated agency representative

Responsibilities

The team consisting of one professional, parent(s)/guardian(s) and the child is responsible for:

1. ensuring involvement of the child unless one or more of the following compelling reasons exists:

    - the child chooses not to participate;
    - the child's level of language development indicates that he/she would not understand the conversation/dialogue;
    - the child has demonstrated in a prior meeting(s) that he/she is unable to constructively participate in the process from a behavioural perspective;
    - the information to be shared between the team members and the parent(s)/guardian(s) could be harmful to the well-being of the child.

2. selecting the Individual Support Services (ISS) Manager, recognizing that the role is open to the parent/guardian, the child or the professional, based on the individual's

    - understanding of and commitment to the role;
    - ability to facilitate a collaborative and team approach;
    - ability to maintain contact with those involved in the case;
    - projected ability to remain as the team leader for the duration of the team's activity;
    - ability to support the involvement of ALL members equally;
    - knowledge of related services and supports;

3 developing the individual support services plan, reflecting the individual contribution of each person and the commitments of each person/agency;

4. ensuring support services and interventions provided are documented;

5. ensuring ongoing review of the ISSP to evaluate the outcomes and effectiveness of each team member's component of the plan;

6. recording date of termination of service and reasons;

7. continually checking at each team meeting to see if other agencies or divisions of agencies have become involved in the delivery of consultative or direct services to the child and when this occur moves the process to the next stage outlined below.

Where the team is comprised of more than one member of an agency they are responsible for:

1. selecting the Individual Support Services (ISS) Manager. The person who has functioned in this role prior to the formation of this individual support services planning team may continue in this role for the team, if that is deemed appropriate, or another person may be selected based upon that individual's:

    * understanding of and commitment to the role;

    * ability to facilitate a collaborative and team approach;

    * ability to maintain contact with those involved in the process;

    * projected ability to remain as manager for the duration of the team's activity;

    * ability to support the child and the family's involvement and decisions where the parent and child have opted not to assume the role;

    * knowledge of related services and supports.

2. developing the individual support services plan, reflecting the individual contributions of team members to the plan and the commitments of each agency in terms of resourcing, etc.

3. ensuring support services and interventions provided are documented.

4. recording date of termination of service and reasons.

5. ensuring ongoing review of the individual support services plan to evaluate program outcomes and effectiveness, in particular with

respect to **each** team member's component of the plan.

6. ensuring written reports are submitted to the individual support services manager when it is not possible for a team member to be physically present for the actual meeting(s).

7. ensuring all relevant information/records on the child are made available to the team in accordance with policies for consent/confidentiality, and that such information is provided to the person replacing the team member to ensure continuity and minimum disruption of service.

8. ensuring team members respect the role of all transdisciplinary team representatives.

9. completing the child profile, communicating service needs and resource requirements.

10. ensuring goals are established which take into account the role and responsibilities of each agency and the resources available to meet child needs.

Appendix A describes the role and potential contribution of some individuals who may be part of the individual support services team.

Appendix B is provided to assist the Integrated Support Services Manager in facilitating or problem solving during a team meeting.

Appendix C contains sample forms required for the completion of an ISSP, and Appendix E provides checklists to support the role of the Individual Support Services Manager.

Initiating an Individual Support Services Plan

Children may enter the support services planning process at several stages in their lives. It is important to ensure the provision of a continuum of services at all developmental stages. To ensure that children's needs are identified and appropriate plans developed, there are at least three key stages when the support services planning process could be activated.

Key stages to initiate support service planning ...

Stage One	a child at birth is identified as being at risk or has a special need
	or
Stage Two	a child presents with a special need subsequent to birth and/or during the preschool years
	or
Stage Three	a special need is identified during the school year

The support service planning process is the same for all children whenever they enter the process. A key player in the coordination of this process is the Individual Support Services (ISS) Manager. The ISS Manager facilitates the collaboration between all team members and ensures that all members provide the supports and services agreed to in the ISS plan.

The ISS Manager:

- schedules meetings
- determines membership of team
- ensures the profile is completed and sent to Child Services Coordinator
- facilities ISSP meetings
- ensures the ISSP is written and signed during meeting
- ensures issues and concerns re - the ISSP process are constructively communicated to the Regional Integrated Services Management Team
- sets date of next meeting
- utilizes a problem solving approach during the planning process
- acts as a facilitator not a chair person
- accepts written reports from members who cannot be present and tables them at the team meeting
- inserts a letter in the child's file when the support services planning process is terminated

A description of the three stages when support service planning could be initiated follows.

Stage One: Early identification (birth)

Early identification is a critical component to the process. All newborns and their families identified to be at risk are referred to the Community Health Nurse and are followed during the preschool period. The Community Health Nurse or the parent normally assumes the responsibilities of ISS Manager during the preschool period:

* when no other services/agencies are involved, or

* until new members from other agencies are involved.

If other agencies/services are involved the Community Health Nurse, in cooperation with the parent/guardian will assess the need for convening a support services planning team meeting to provide all service providers with the opportunity to communicate relevant information, avoid overlaps in planning and prevent gaps in services delivery. When an **ISSP** team meeting is convened, the ongoing ISS Manager will be selected by the team members.

Stage Two: Preschool (post birth)

Many children are identified with special need(s) during the period subsequent to birth or during the preschool years. In contrast to Stage One, the support services planning process for Stage Two differs only to the extent that service providers may originate from the Health and/or the Social Services sectors (consultation would be provided by the itinerant teachers for the visually impaired and/or itinerant teachers for the hearing impaired where children have a significant visual or hearing loss). Service providers from both these agencies are typically involved with preschool children.

With Stage Two, the agency or service provider which initially identifies and begins to meet the needs of the child and family will decide with the parent(s) who will assume the responsibilities of the ISS Manager, at least on a temporary basis. One of the major functions of the ISS Manager is to ensure the necessary services or referrals are actioned appropriately and expeditiously. At the point when two or more services become involved the need for a broader team meeting is assessed by the ISS Manager. Should a meeting occur, the **ongoing** ISS Manager is determined by the team members. If the individual support services planning process is initiated in the preschool period very few children should reach school age without having their needs identified and addressed.

Stage Three: School age

Based on stage one and two, some children will enter school with an individual support services planning team already in place.

In such cases, the child's ISS Manager is responsible for making contact with the school when the child is 4 years of age, (children of pre-school age who have significant visual or hearing impairment would have itinerant teachers on their pre-school team) in order to involve school personnel on the planning team. Inclusion of school personnel is essential at this point to ensure a successful transition to the school environment.

Some children, however, enter school without having had any specific interventions and may come to the attention of service providers for the first time during their school years.

Section Two

Developing the Individual Support Services Plan in Any Setting

Developing the individual support services plan in any setting

The ISSP process should enable all personnel to feel supported in their work with individual children. It provides parents, children, and professionals with a mechanism for input, formal planning and ongoing collaboration. It documents the support services being given by most other if not all providers in Education, Health, Human Resources and Employment and Justice and the linkage between those and the child's/youth's plan. It serves as a tool to track individual strengths and needs in terms of agreed upon goals related to specific interventions and learning.

The model for the ISS planning process presented in Figure 1 (and outlined in detail in Appendix D) illustrates the steps for planning for individual children/youth whose needs are identified at any time during the developmental years. Individual agencies may have developed their own similar planning processes and **should bring their process and vocabulary in line with that outlined in this document to ensure everyone is using the same jargon, improving communication between parents and all service providers.**

The process is sequential and the point of entry will depend on the child's needs and whether there has been prior involvement. As described earlier, some children who come to the attention of your agency will be already receiving services from other agencies and have an ISSP and an ISS Manager in place.

STEP	ACTION	WHO
Screening and Identification (possible entry point)	• need is recognized • begin to clarify problem • begin keeping a record of the child's strengths and needs in the area	• child • parent • service providers
Assessment and Exploration of Strategies	• use a problem solving process • target specific strategies • if school age and the child is using "regular" curriculum • add to record of the child's strengths and needs	• child • parent • service providers from Health, Human Resources and Employment, Justice and Education • other agencies
Ongoing Evaluation and Monitoring (possible exit point)	• evaluate strategies • if successful, terminate process • if not successful: - give it more time or - advance to next step	• parent • service providers from Health, Human Resources and Employment, Justice and Education • other agencies
Referral to Individual Support Services Planning Team	• ensure pre-referral activities completed • ensure the child's records are updated • complete referral form • obtain consent to share information	• parent • Individual Support Service Manager (if other than parent) • child • service providers
Team Meeting	• ISS Manager calls meeting • elect ISS Manager (if one is not in place) • arrive at consensus on strengths and needs; and service areas • arrive at consensus on priority goals • problem solve to arrive at plan • identify supports and services • set responsibility areas • set date for review meeting	• child • parent • ISS Manager • service providers from Education, Health, Human Resources & Employment, Justice, community persons and others as needed
ISS Plan Developed	• continue with pre-referral activities or complete remaining portions of the ISSP	• child • service providers from Education, Health, Human Resources and Employment, Justice • other service providers
Implementation of Plan	• team members carry out responsibilities as assigned • ISS Manager ensures responsibilities carried out	• team members

STEP	ACTION	WHO
Review of Support Service Plan	• ISS Manager calls meeting • review child's progress • evaluate success of the ISSP • revise/refine list of child's strengths and needs; and service areas • continue with ISSP as written or extend or revise ISSP or discontinue ISSP	• team members

Initiation of the individual support services planning team

The entry point in the process for the child is, as noted at the beginning of Figure 1, the step of "Screening and Identification". The first three boxes of the figure are known as the "pre-referral stage". This is a stage where a concern has been identified and specific action is being taken however there may not yet be sufficient reason to "refer" (e.g., to initiate a transdisciplinary support services planning team). The emphasis at the pre-referral stage is on problem solving and communication between all partners. The interventions at this stage would typically be less intensive, since more involved interventions would necessitate the formalization of a individual support services planning team. While the interventions may be less intensive at this stage, the need to record the strategies used and all assessment findings (informal and/or formal) is critical.

The needs of some children will be met during the pre-referral stage and the process may not need to continue to the "ISSP Team Meeting" stage. Ultimately, however, some children will require formalized team planning and so, if the pre-referral stage has not yielded the desired results, you will need to determine if and when a referral should be made and a ISSP team initiated.

Which children might need individual support services plans?

- any child for whom you have specific concerns and who are unable to be successful following all reasonable attempts to explore strategies
and/or
- any child whose emotional and/or behavioral difficulty or disorder is

preventing him/her from being successful with social/learning interactions or causing him/her to be consistently disruptive to others

and/or

- any child whose mental health needs prevent him/her from coping effectively and/or puts him/her at risk of self-harm

and/or

- any child whose communication disability or disorder is preventing him/her from being successful learning/interacting

and/or

- any child with a sensory disability which interferes with his/her ability to attain normal developmental milestones at the pace of non disabled peers

and/or

- any child with a cognitive and/or physical disability which is impeding growth and development

and/or

- any child, of school age, who has mastered many or all of the outcomes of the subject, course or program prior to instruction

Before the team meeting

Prior to initiating a team meeting, you should ensure that:

- your records on the child are current and contain information on the child's strengths and needs, the area of concern, assessments you or others have done, the strategies/supports/interventions which were tried and the results

- you are satisfied that all reasonable pre-referral activities have been completed without the desired results

- you have taken time to analyze the information you have collected, and looked for patterns which might help to clarify the problem; further assessments have been completed as necessary to help clarify the problem; you are prepared to articulate your understanding of the child's strengths and needs

- you have spent some time with the parent(s)/guardian(s) and child/youth and with the child to understand their perception of the problem.

- you have spent time with the parent(s)/guardian(s) and child/youth

explaining the ISSP process and their role ensuring they are knowledgeable of and comfortable with the process

The team meeting

The team meeting is a continuation of the problem solving process begun at the pre-referral stage. It is a time for those who work with the child in all settings, and those with relevant knowledge that can help, to come together with the child and parents to discuss and plan appropriate support services. It is important to keep in mind that the focus is problem solving and that the child is at the center. The team need not be a large group. Its membership can vary from time to time. Small groups may include a community health nurse, a parent and a child; a special education teacher, classroom/subject teacher and the parent, or a social worker, child management specialist, parent and child sitting together for 20 minutes .

When multiple service providers are involved a more structured and longer meeting may be needed initially. However, it is important to keep in mind that large meetings can pose certain problems and should be avoided when possible. Every attempt should be made to keep the number small and the meetings efficient. To avoid large numbers efforts should be made to collect information from those who might not need to attend. Several persons from one agency for instance may not be necessary and in such circumstances, arrangements should be made to obtain their input in other ways (e.g., written report, phone call, teleconference).

Conversely, a larger group, a more structured meeting and/or a longer time frame may be needed in certain situations and usually for the initial meeting about a child.

The team meeting is:

- child-focused
- a forum for shared decision-making
- a means to acquire solutions to problems
- a place for respectful honesty
- inviting and comfortable for all members
- a place where everyone's expertise and point of view is valued
- positive and optimistic about the child's future

The team meeting is not:

- service provider-focused
- a forum for confrontation or argument
- simply a means to acquire resources (although this may be a by-product of the process)
- intimidating for parents, service providers, or for the child
- a place where experts will solve the problem for everyone else
- negatively focused

What happens at a support services planning team meeting?

Format for a first individual support services planning team meeting

Opening and organizing

- members are greeted and introduced by the ISS Manager (if one is already in place) or chairperson. These names are recorded (refer to page 103)
- the team chooses an ISS Manager (who chairs the meeting), a recorder (to keep minutes) and any other function that the team feels it needs

Getting to know the child

- the team members, including the child, share their understanding of the child's strengths and needs and these are recorded in the ISSP (refer to p.101 and 105)

Developing an action plan

- the team uses a consensus-building process to arrive at and prioritize goals for the child and these are recorded in the ISSP (refer to p. 107). Transitional needs are considered.
- the team agrees on strategies, approaches and /or interventions to meet the goals (see page 107) and service areas (see page 109) which need to be addressed
- the team ensures that measures are taken, where services overlap, to minimize duplication and that a consistent service delivery approach is utilized
- the team uses a problem solving process (refer to Appendix B) to identify the supports and services required for each goal and negotiates what is possible; the final agreed upon list of supports, services and recommendations for each goal is recorded in the ISSP (refer to p.109)
- the team sets responsibility areas by consensus and these are recorded in the ISSP (refer to p.107) "Implemented by, "Who will be Responsible for Obtaining the Service and Person/Agency Responsible for Implementation"

Closure

- ISS Manager summarizes the decisions made at the meeting and ensures that team members understand their responsibilities
- the date for the next review meeting is set and recorded in the ISSP
- if the recorder has kept the records on the actual ISSP form, then this may be signed by team members before the meeting is closed (see page 111)
- members are thanked and the meeting is closed.

After the support services planning team meeting

If the meeting follows the procedure described previously, most of the **ISSP** should be complete by the end of the team meeting. It is especially useful to record directly on the ISSP form during the meeting whenever possible since this eliminates the need to rewrite the ISSP after the meeting.

During the meeting, the following components of the ISSP would have been written:

- the child's strengths and needs
- the priorized goals
- supports and services (educational, health related, human resource and employment and/or justice services)
- responsibility areas

and when necessary the kinds of approaches, strategies, resources, and environments, etc. which will be used. More information on each of these components is contained in Section Three (p. 35).

After the meeting, the individual team members with responsibility for implementing the ISSP need to complete the specific portion related to their service. For example, an occupational therapist should use the ISSP that comes from the team meeting to develop his/her therapy plan. School/board office personnel, usually the special education teacher and relevant classroom/subject teacher(s), get together to complete the teaching portion of the ISSP which will incorporate the contributions of the other team members. Similarly a social worker and a child management specialist will utilize the goal statement to generate their detailed action plan. All members will need to complete the following:

- using the goals generated at the team meeting, identify the objectives (outcomes) (smaller steps) needed to reach the goal;

- follow the direction set at the team meeting to note the interventions, supports, approaches, resources and evaluation methods which will be used (depending on the child, this need not be overly detailed);

- if the ISSP includes an area for which additional expertise is needed (e.g., a person with expertise in technology, a mentor in the area for which the

child has an ability) include the relevant person, or access the recommended resource materials to help write this portion of the **ISSP**;

- if the ISSP includes an area for which the child is already receiving services (e.g., from the Community Behavioral Services Program) link with that appropriate individual/agency to ensure programming consistency before developing a similar program for another setting.

- link the goals which were generated at the meeting to relevant agency guidelines where necessary;

Once this has been done the ISSP is complete. It should be kept in the child's confidential file and only shared with the parents and those individuals who have responsibility for implementing the ISSP, unless the parents and/or child have given written permission otherwise.

Implementing the ISSP

The ISSP which has now been written defines what is expected of the child, parents and service providers.

The next logistical step is to develop a schedule. The **ISSP** defines who is responsible for what, who will be helping the child, as well as the specific supports and services (see page 107 & 109). These should be adhered to during implementation. The ISS Manager is responsible for assuring that everyone fulfills his/her responsibilities.

Consider ...

Are there interventions which should occur consistently in all settings?

Often, using a consistent approach across settings is the key to successfully implementing an ISSP. A good example of this is in the area of appropriate responses to inappropriate behaviors.

If for example a Behavior Management Specialist is involved with a child prior to a ISSP meeting, it is important for the others involved to know that there may already be a written behavioral plan in place which everyone

can draw, instead of duplicating work that has already been done.

Example: Shannon

Shannon, aged 8 is diagnosed with Attention Deficit Disorder and developmental delay. Shannon spends a portion of his day in the Grade Three classroom and some time in a small group setting with a special needs teacher. His out-of-seat behavior has been identified as extremely disruptive at home and at school. His parents have identified this as being a concern in the home at mealtime. The Behavior Management Specialist has suggested the use of a positive technique for the parents and teachers to use when inappropriate out-of-seat behavior occurs. If this intervention technique is agreed upon by the parents, the BMS, the teachers and others working with Shannon, it should be considered for adaptation in all environments where out-of-seat behavior occurs.

Monitoring and Reviewing the ISSP

Once implemented, the ISSP will require monitoring and reviewing. Twice annually, the ISSP Team is required to review the plan; however, mini-meetings can and should occur as necessary. For example, the social worker and parent may want to get together for brief informal meetings more frequently; the special education teacher and the classroom/subject teacher may schedule some planning time if behavior problems surface; the teacher, parent and Behavior Management Specialist may want to meet as necessary or the ISS Manager may want to liaise periodically with another agency in order to monitor progress and ensure that everything is going well. The initial team members may not be required to attend review meetings. Their input for review meetings can be obtained by the ISS Manager or other members of the team.

The ISSP is normally reviewed twice annually; therefore, often the ISSP will identify long-term goals and then identify only those short-term objectives that the team anticipates will take them up to the next review period. This could then mean identifying objectives for a four to six month period. You may wish to experiment with more frequent review meetings. This could mean that the objectives will be identified for shorter periods of time and thus there will be fewer of them. This may work well for a child who is expected to make quick progress, for a child whose physical condition is expected to change rapidly throughout the year, or for a child whose behavioral needs are such that there is a high degree of unpredictability to the result of the plan. In each of these cases, the ISSP will likely need to change over short intervals and the team may find it difficult to project beyond these shorter periods. A convenient arrangement for some schools is to schedule the ISSP review meetings to coincide with the normal parent-teacher interviews avoiding the need for parental travel to multiple meetings. The schedule of review meetings and the subsequent length of the ISSP should be flexible depending on the child and the circumstances, however the ISSP should not go longer than six months without some form of review.

Format for review meetings

Opening and organizing

- members are greeted by the ISS Manager
- any new members are introduced

Revisiting the child's strengths and needs

- the child's strengths and needs from the existing **ISSP** are revisited and revisions made as necessary; these are recorded in the **ISSP** (refer to p. 37 and p 105)

Refining the action plan

- existing goals are discussed one by one regarding the child's progress and the appropriateness of each goal; a revised set of goals is recorded in the **ISSP** (refer to p.42 and p. 107); goals discontinued are noted and the date (eg. d. June 21/97) goals achieved are noted with "a" and the date (eg. a. June 1, 1997)
- the same process described for the initial meeting is used to develop an action plan for the new goals; the effectiveness of the previous strategies, interventions, approaches, materials, supports and services from all agencies is reviewed and suggestions for changes are identified, negotiated and recorded in the **ISSP** (refer to p.107 & 109)
- responsibility areas are determined through consensus and these are recorded in the **ISSP** (refer to p. 107 & 109)
- transitional planning issues/needs are discussed and have been incorporated in the plan

Closure

- the ISS Manager summarizes the child's progress, the team's evaluation of the plan and the decisions made at the meeting
- the date for the next review meeting is set and this is recorded in the **ISSP**
- if the recorder has kept the records on the actual **ISSP** form, then this may be signed by team members at this time
- members are thanked and the meeting is closed

During the review process, the team will need to determine whether or not the

goals and/or the short-term (objectives)outcomes have been met. This will guide the team's decision-making.

If the goals and/or objectives (outcomes) have been met, the team should explore the following questions:

- Is the child now able to proceed without adaptations or modifications? If so, the plan is terminated and a letter noting this is signed by the ISSM and placed in the child's file.
- What does the child need to learn next?

If the goals and/or objective (outcomes) have not been met, the team should explore the following questions:

- Was the ISSP a supportive and useful document?
- Were the goals and objectives (outcomes) appropriate? If not, what would be more appropriate?
- Did the child have the prerequisite skills required to accomplish this goal?
- Was scheduling a factor?
- Were the materials, methods, supports and services appropriate?
- Was the assignment of responsibility appropriate?
- What gains did the child make?
- What responsibility did the child assume for his/her own learning?
- Did the plan result in increased independence for the child?
- How did all settings reinforce the agreed upon objectives?
- Who should be involved in the revision of the ISSP?

Adapted from Individual Education Planning for Students With Special Needs A Draft Resource Guide to Support Teachers, Province of British Columbia, 1995.

When developing the ISSP, each member of the team should keep in mind that the success of the implementation of the ISSP as a whole rests with the whole team. Any lack of progress or failure of a particular strategy, support or intervention to achieve the desired results should not be seen as the failure of the personnel who had the most contact with the child. The team as a whole decides on the support services plan and the team as a whole must accept responsibility for its outcome. In an atmosphere of collaborative decision-making, there will usually be many successes to celebrate.

Section Three

Writing the ISSP

Writing the ISSP

The ISSP describes the goals that the child will be following, as well as the supports and services which the child will be receiving. In the school setting, the ISSP may replace the prescribed curriculum or aspects of it. The level of complexity of the ISSP is related to the complexity of the child's needs.

An ISSP is needed if...

* the child requires a special service (e.g., Speech Language therapy, Itinerant services, behaviour management interventions)

* the child requires the services of two or more agencies (e.g., Child Management Services and Community Health Nurse)

* the school-aged child will not be using the prescribed curriculum for the grade level or course because:

  - changes need to be made to the outcomes of the subject or course (e.g., deletion/addition of outcomes; changes to the depth of treatment of outcomes: reduced or extended)

  - new courses or programs need to be designed for the child (e.g., an alternate course, alternate curriculum)

The ISSP is written for...

the child	the team
• it describes what the child can do	• it informs you about the effectiveness of your interventions
• it records the child's attainments	
• it validates the child's learning	• it helps you evaluate the child's progress
• it helps the child become more responsible for his/her own learning	• it helps you evaluate your programs and materials
• it helps ensure smooth transitions	• it helps you communicate with the parent, and other service providers

Adapted from Special Needs Information Pack (second edition), Essex County Council, 1988.

What does the ISSP contain?

As referenced earlier, the ISSP need only be as complex as the child's strengths, needs and interventions dictate. For some children, an ISSP may not be more than one or two pages. For other children, a more detailed record needs to be kept. In all cases, the following are the components which should be addressed by the team and, where applicable, each component should be part of the ISSP.

Components of the ISSP

- the child's strengths and needs
- annual goals
- short-term objectives (outcomes)
- specific support services

- responsibility areas
- review dates

The following sections examine each of these components in more detail.

Strengths and needs

At an initial meeting, the team will collaborate to determine a list of the child's strengths and needs based on each member's experience with the child. This is an important part of the team's discussion, since the information shared from the various team members will enable the team to develop a plan which reflects the needs of the whole child.

Strengths

It is important when writing strengths to have a positive focus. In some situations it may seem easier to list the things the child cannot do than to find strengths. While you may feel overwhelmed by the many frustrations which you and the child are having, a list of "can nots" is not very helpful to either you or the child.

For any goal there will be a continuum of progression which can be identified. In other words there is a set of steps and several related pre-requisite skills which lead up to being able to do what the goal requires of the child. When writing strengths (and needs) for a particular area, try and keep this sequence of development in mind. When identifying the sequence of development in certain areas, the team may require the input of someone with expertise in the particular area, such as the speech-language pathologist, the behavior management specialist, a mentor, the physical therapist, the learning resource teacher, the community health nurse or the guidance counselor. Once you have defined the sequence of development and the related prerequisite skills ask yourself, "Where in this sequence is the child currently?" and "What is the best the child can do right now in this area?" When you have identified what the child can do in a particular area, you have identified his/her strengths. Other strengths may include predispositions, talents, innate abilities, attitudes and physical skills which the child can bring to bear on the goals which will be set for him/her.

Example: Tanya

As a result of Tanya's cerebral palsy, her left side is weak and she has no left hand grip. The team has identified putting on her coat as an area of concern. The occupational therapist has identified some parameters which need to be considered for one to be able to independently put on a coat, such as: motivation, cognition, organization/sequencing, physical skills (e.g., balance, arm and hand range of motion and dexterity) and main area of concern is physical skills. Some physical skills which are necessary to put on a coat are:

- getting the coat
- balancing oneself while putting on the coat
- positioning the coat appropriately
- placing first arm in coat
- pulling coat around back
- placing second arm in coat
- adjusting coat
- connecting zipper
- pulling zipper up.

Currently, Tanya has sufficient skills and abilities related to putting on her coat in the areas of motivation, cognition, organization/sequencing and sensory processing, as well as the following physical strengths:

- Tanya can get her coat
- Tanya has good sitting balance
- Tanya can raise her left arm to position her coat on it
- Tanya can use her left arm as a stabilizer
- Tanya has full range of motion of her right arm.

These are Tanya's strengths as relates to putting on her coat.

The child's strengths are the starting point for his/her learning and for your teaching/intervention/support, and so the identification of these will be extremely helpful to you as you plan your activities.

Needs

The same developmental progression used to identify the strengths, is used to identify the needs. If the strengths are the ***best*** the child can do in the area, then the need is the ***next step***. Once you have identified the best the child can do, simply ask, what is the logical next step or steps the child must learn to do?

Example: Jamie

The team had identified for Jamie:

Strength: Jamie can add two 2-digit numbers with regrouping.

The next logical step in this progression is for Jamie to multiply one digit numbers.

Need: Jamie needs to be able to multiply one digit numbers.

Sometimes the progression is less linear, where the next step depends on the development of a related or underlying prerequisite skill in another area. This skill is also a need, since progression forward depends on its acquisition. For some children, it is not only the skill levels which are directly related to the goal which need to be considered, but related prerequisite skills may be missing. For example, with Jamie, while his curricular strengths and needs with regard to multiplication have been identified, other areas may need to be explored such as visual scanning, short-term memory and skills with copying. He may be found to also have an organizational difficulty and so find it difficult to keep numbers lined up in columns. This particular difficulty might impact on a variety of areas of Jamie's development, so further assessment into this area should be conducted. At the very least, this will impact on his success in mathematics and so should be addressed within the **ISSP**. If the difficulty is extensive it could become a goal area in and of itself.

Example: Tanya

As above, the team had identified for Tanya:

Strength: Tanya has sufficient skills and abilities related to putting on her coat in the areas of motivation, cognition, organizations/sequencing and sensory processing, as well as the following physical strengths:

- Tanya can get her coat
- Tanya has good sitting balance
- Tanya can raise her left arm to position her coat on it
- Tanya can use her left arm as a stabilizer
- Tanya has full range of motion of her right arm.

Therefore, the remaining skills in the sequence are identified as her needs:

Need:

- balancing herself to put on her coat
- positioning the coat appropriately
- placing first arm in coat
- pulling coat around back
- placing second arm in coat
- adjusting coat
- connecting zipper
- pulling zipper up.

As mentioned earlier, it is very important, and more productive, to maintain a positive focus when writing the ISSP. This does not mean that information is omitted or that obvious difficulties are ignored. Rather, information is presented clearly and objectively, without negative judgmental language. For this reason, it is very important that ***needs*** be used, and not ***weaknesses.*** Another obvious benefit to using the ***needs*** wording is that in doing so, the specific outcomes, the next component of the ISSP, flow directly from the needs and are much more easily written.

Weakness	Need
Scott can't catheterize himself	Scott needs to self catheterize
Patricia relies too much on pictures when reading	Patricia needs to utilize semantic cues to derive meaning from a story
Joey screams loudly whenever there's company in the house	Joey needs to use his communication board when he wants to express "no"
Janet has poor retention	Janet needs to utilize her mnemonic strategies to remember faces
Billy should behave himself	Billy needs to sit in his seat for 20 minutes intervals
John refuses to accept the parameters of his probation orders	John needs to comply with the directives outlined in his probation orders

A final point regarding strengths and needs is that for the actual ISSP itself, there is no need to include unwieldy lists of strengths and needs. While the number will vary from child to child and from time to time, generally the two or three most relevant strengths which represent the best the child can do in each area should be sufficient. There is no need to list several strengths which are obvious prerequisites to a strength already listed. Similarly, for each area, two or three needs leading directly from these strengths should be plenty to form the basis of a program.

Goals

The overall goals are brainstormed at the team meeting. Goals are most often set as year-long goals; however, it is possible to define a component of an ISSP which will be less than one year in duration. In any case, the goals are more long term projections of what the child will have attained. The timeframe will be determined by the child's needs.

It is pointless to develop an ISSP with so many goals that it would take years to complete. Since there might be many goals which the team would like the child to attain, it is important that the team priorize these and derive from them a reasonable and attainable set of goals which can be accomplished, usually within one year. These goals are part of the ISSP. Sometimes the priorities of various team members might not coincide. A consensus building process must be used to resolve conflicting priorities, since it is unproductive to try and accomplish an unreasonable set of goals in a given timeframe.

Factors which should be considered when choosing priorities

- child's/youth's priorities
- the child's/youth's context
- the time required of the caregiver/implementor in order to meet the goals
- contribution to long-term growth and development (social, intellectual, career)
- chronologically age appropriateness
- contribution to meeting needs in environments child finds him/herself on a daily basis
- contribution to a well balanced plan
- attainable in one year.

Adapted from Using Our Strengths Programming for Individual Needs (1992)

Goals are global statements which define what instruction/intervention in a particular area is ultimately leading to. It should give your day-to-day work a sense of purpose, since it is what you are striving toward. The degree of specificity of the goal depends entirely on the anticipated rate at which the child will likely work toward the goal. For example, two children may be working toward improving their ability to handle criticism. For one child whose progress has been very slow in this particular area, the goal may be "to maintain constructive behaviour for one hour per day". Based on previous coaching and experience, the other child is anticipated to work at a quick pace

with respect to maintaining positive reaction pattern. The goal for this child for the same time period may be to "react positively 8 hours per day". The measure of specificity must always be the individual child and what you project will be the progress in this area in the given time frame.

It may be helpful, once the strengths, needs and goals have been decided upon, to organize the strengths and needs as they relate to specific goals or at least to the area which the goal is targeted. This facilitates the process of writing objectives (outcomes) later, since the strengths in a goal area represent the starting points and the needs in that area can be worked into the specific objectives (outcomes) leading toward the goal.

Example: Tanya

The area of concern has been identified as putting on her coat. The team has considered the conditions under which Tanya will need to perform this skill routinely at home and in school (e.g., a busy, noisy, crowded corridor) and the fact that Tanya no longer wishes to be helped by her mom or the student assistant but prefers independence as much as possible. The following goal becomes part of Tanya's ISSP:

Goal: Tanya will put on her coat independently at home and in the hallway beside her locker.

Objectives (Outcomes)

Objectives (outcomes) are the smaller levels of accomplishment needed to take the child from where he/she is right now to where the team ultimately wants him/her to be. While goals are the broader statements projecting the child's progress, objectives are the markers of progress along the way to the goal. Objectives (outcomes) are more specific and the work towards them is shorter in duration. The goal defines the road on which you are traveling. When writing objectives (outcomes), think, "Realistically, how far down that road will we get in the next ____?" The blank can be filled in with the desired time period (e.g., one month, six weeks, one term).

Example: Tanya

Goal: Tanya will be able to put on her coat independently in the hallway..

Her strengths and needs relative to this goal have been identified in the previous examples. Recognizing Tanya's age (she is 12 years old), the unlikely possibility that her physical skills will improve further and she wants to be as independent as possible, the team (of which Tanya is an active member) has decided against further attempts at remediating her physical skills. Therefore the team in consultation with the physical and occupational therapist will have decided that compensatory techniques will be used by Tanya to attain the identified outcomes.

Outcome	Technique
Tanya will stabilize herself while putting on her coat.	Tanya will sit on a stool placed beside her locker while putting on her coat
Tanya will use the compensatory technique to don her coat	Tanya's compensatory technique for putting on her coat involves: - positioning the coat on her lap - placing left (weak) arm in coat first using right arm to assist - pulling coat around her back with her right arm - placing her right arm in her coat - using her right arm to adjust the coat and collar
Tanya will use the compensatory technique and adapted zipper pull to fasten her coat	- while sitting, Tanya will use her left arm to hold the left side of her coat stable on her lap and using her right hand, will connect the zipper - she will use a large ring attached to the zipper pull to pull the zipper up.

If strengths and needs are linked with the goals as described, then the "strength" listed for each goal can represent the starting point, where the child is now. The identified "needs" can then become translated to a goal.

The specific details related to the services provided by the community health nurse, the behavior management specialist, the social worker, the physiotherapist, teacher or any other service provider who may be involved, are written by them after the team meeting. These specific details are the day-to-day planning component of the ISSP and are within the expertise of each service provider to determine. The goals agreed upon at the team meeting and contained in the **ISSP** are the unifying feature which ensure that each provider's outcomes work in concert. Each service provider will maintain a record of their services and provide relevant information re progress at each ISSP meeting.

Specific support services

During the team meeting, the team will have discussed and agreed upon the specific support services which the child/youth needs to receive. The ISS Manager is in a position to ensure that any supports and services which have been committed from any individual or agency are provided. For some children/youth, the supports required will be of high intensity and involve a variety of agencies and individuals. For other children, supports will be far less intensive and intrusive Many children/youth can be assisted by natural supports, for example having a peer carry his supplies while he maneuvers the stairs with his canes, or having a buddy use non-carbon paper so that he can have a copy of the class notes. The team needs to determine the appropriate and least intrusive level of support considering both the child's/youth's needs and the ultimate goal of independence. The following system for classifying supports may be useful in team meetings when completing a child's/youth's profile. Keep in mind that the level of support should be determined for each specific area of the program rather than as a global classification for the child (see Profiling the Needs of Children and Youth for specific details).

Level 1 - Intermittent

Level 1 means that this child/youth requires between 1 and 6 hours of service (in all settings) per week; it does not necessarily mean that 1:1 support is required.

Level 1 supports are provided on an "as needed" basis for children who do not always need the support(s), or they can be short-term supports which are needed at specific times (e.g., during transition periods). Some examples include providing specific tutorial instruction from the special education teacher for a child who requires the help in certain academic areas but not in other areas; providing a respite worker to aid with mobility for a child who requires help after a surgery with the expectation that increased mobility will occur; providing a specific enrichment unit on a topic of interest for a child who is exceptionally able; providing community support to a youth who is in the transition period between school and work; providing specific instruction from the Community Health Nurse for a child learning how to self-catheterize.

Level 2 - Limited

Level 2 means that this child/youth requires 7 to 12 hours of service (in all settings) per week, it does not necessarily mean that 1:1 support is required.

Level 2 supports refers to an intensity of supports characterized by consistency

over time (e.g., a relatively low level of support but on a regular basis). Examples would include an ongoing physiotherapy program for a child who requires consistent intervention for that portion of the individual support services plan and who, with specific adaptations, can function more independently in other aspects of his/her program; ongoing monitoring by the itinerant teacher for the hearing impaired for the child who requires assistance to ensure that his/her hearing aid is maintained, that the parents, day care providers and teachers are instructed in the use of the amplification system and that the team is aware of appropriate accommodations regarding positioning in all environments (vehicle, church, home, school); a specific alternate course designed for a child who requires direct instruction from the special education teacher in the area of personal care/daily living skills; support for the child who is working with a mentor and who needs periodic but regular meetings with the teacher to assess the achievement of the goals of his/her contract; community support for the youth who is learning to generalize positive social skills.

Level 3 - Extensive

Level 3 means that this child/youth requires 13 to 18 hours of service (in all settings) per week; it does not necessarily mean that 1:1 support is required.

Level 3 supports are characterized by regular input (e.g., daily) in at least some environments (e.g., the classroom, community environments) and not time-limited (e.g., long-term support). This would include support for the child who is gifted and who is working on an individualized accelerated program for most or all of his/her program; interventions from the behavior management specialist and the guidance counselor for the child who requires individual counseling on an ongoing basis and an extensive behavior management program which is implemented at home and at school.

Level 4 - Pervasive

Level 4 means that this child/youth requires 19 or more hours of service (in all settings) per week; it does not necessarily mean that 1:1 support is required.

Level 4 supports are characterized by constancy and high intensity and are usually provided across environments. Children requiring a pervasive level of support may be on a completely alternate curriculum in school and/or may be receiving interventions from a variety of agencies and individuals. Examples include a child who is multiply handicapped and is receiving interventions from a developmental pediatrician, a "challenging needs" teacher, a student assistant, and a physiotherapist; a child who is living in open custody and who is receiving intervention from a guidance counselor, a special education teacher, a behavioral counselor and a youth corrections social worker; a child who is exceptionally

gifted, who may be on a completely alternate curriculum and accessing independent studies in environments outside of the school (e.g., a research facility, a post-secondary institution, working closely with a mentor).

Support needs to be discussed in its broadest sense, since not all supports are material, human or financial in nature. Example of this kind of support include scheduling joint planning time to enable a social worker, classroom/subject teacher and a behaviour management specialist to meet with the special education teacher on the child's program providing a parent or teacher with consultation from the behavior management specialist regarding a child with challenging behaviors. While material, human and financial supports are necessary in many cases, other kinds and degrees of support should not be overlooked.

Responsibilities of team members

At the team meeting, decisions will be made regarding the goals toward which the child will be working and the specific supports and services that the child will require to achieve his/her goals. The team then needs to assign responsibility to team members for ensuring that a particular goal is met, for providing a specific support service, for accessing a particular piece of material or equipment, or for whatever else is required by the support services plan. Again, once responsibilities have been assigned, the ISS Manager is in a position to ensure that they are fulfilled. In a truly collaborative team, individuals will readily acknowledge the areas where they can provide the required assistance and will support each other's efforts to do so. As discussed earlier, while individual members of the team will have specific areas for which they will be responsible on a daily or intermittent basis, the team as a whole has overall responsibility for the support services plan since the decisions will have been made collaboratively.

The ISSP (as shown on page 107) provides space for the writing of the prioritized goals and relevant details.

Example:

Goal	To Be Implemented By	Environment	Date of Review
June will remain with assigned activities for 30 minutes	Mom, respite worker, student assistant, teacher, leaders	Home, school, Girl Guides	June 10, 19–

The service area section of the ISSP as shown on p. 109 outlines area of responsibilities which are important if the child/youth is going to be provided with every possible opportunity to meet the goals set in his/her ISSP:

* Service Area (proposed review date)	Description of Service Needs and Preferred Service Options	Is Service Available (Yes or No)	Who Will Be Responsible for Obtaining Service	Person /Agency Responsible for Program Implementation	Date Service Obtained	Review Date
Health	Audiological assessment at James Paton Memorial Hospital	Yes	R. Ruby, Public Health Nurse	Community Health		June 10, 19--

Decisions regarding where aspects of the child's program will be delivered and/or where the child will receive a particular service are inextricably linked to the setting of responsibility areas. While some constraints exist in terms of the options for service delivery in certain situations (e.g . the physical space within the day care or school building), wherever possible, decisions regarding the environment(s) for the delivery of the program should be dictated by the child's needs and the goals as outlined by the team. The child's program should be implemented in environments with his/her peers except for compelling reasons. In the school setting, if a child is to receive any aspect of his/her program in a setting different from his/her peers, then the support services planning team must demonstrate that the reasons for doing so are compelling, such as those outlined below:

Compelling reasons ...

- to protect the dignity and privacy of the child'
- where it has been demonstrated that the child's behaviour disruptive to point of adversely affecting the instruction of other children;
- where the natural environment is other than the grade/subject area classroom; and/or
- where the small group or individual tutorials have been deemed appropriate during the support services planning process.

Section Four

Trouble Shooting

Common difficulties when writing ISSPs

The process of writing ISSPs should be fairly straightforward when all of the information is available and is well organized. Difficulties may occur in writing **ISSPs** for some of the following reasons:

Difficulty: Goal is too vague

Example: Jason

Goal: Jason will develop age appropriate social skills

The problem:
It is very difficult to determine which of Jason's strengths relate to this particular goal since one cannot get a picture of exactly what Jason will be doing when he arrives at this goal.

Alternative goal: Jason will greet strangers verbally.

From here, we can see that related strengths might be:

Strengths: Jason ...
- readily smiles at strangers.
- expresses affection easily.
- likes to meet new people.

Jason's needs related to this goal, which easily translate into outcomes, might be:

Needs: Jason needs to...
- respect personal space when meeting new people.
- use one the following phrases when meeting new people:
  Hello, my name is Jason.
  It's nice to meet you.
  How do you do?

Difficulty: Fuzzy language

Example: Sarah

Strength: Sarah is emerging as a reader.

The problem:

This statement can describe almost any child. In an attempt to be positive, the statement actually says very little which will help us teach Sarah.

Alternative strengths:

Sarah holds a book with the appropriate orientation.
Sarah recognizes 6 common environmental print symbols.
Sarah can remember short passages from familiar storybooks.
Sarah can read her name and recognizes 8 letters of the alphabet.

Example: Tom

Goal: Tom will read at a mid-grade 2 level.

The problem:

How does one define a "mid-grade 2" reading level? How will we know when Tom has arrived there? Reading is such a complex process that a statement this broad does not give one a picture of Tom's reading skills.

Alternative goal:

Tom will make use of syntactic cues when reading new passages.

Difficulty: Outcomes not stated in observable terms

Example: Colleen

Outcome: Colleen will improve her social skills

The problem:

How will one know when Colleen has improved her social skills? What will she be doing when she has improved these skills? This statement doesn't give a picture of Colleen and what she is working toward; it could be descriptive of almost any child.

Alternative outcomes:

Colleen will attend teen dances with her circle of friends.
Colleen will maintain eye contact during a 5 minute conversation with a friend.

Example: Shannon

Outcome: Shannon will improve her fine motor skills.

The problem:

This is so broad for an outcome that one cannot get a sense of Shannon's skills or what she needs to develop in the fine motor area. How will we know, at the end of the review period, whether she has achieved this outcome?

Alternative outcome:

Shannon will print her full name independently, using a pencil grip.

Difficulty: Needs or outcomes stated as caregiver performance instead of child performance

Example: Joey

Need: Joey, a 4 year old, needs a book read to him.

The problem:

Individual support services plans should reflect what the child *needs to be able to do*. The need should be active, and use a verb to show what the child needs to learn. Joey is blind and is in the process of learning braille. In the mean time his parents are anxious for him to keep up with his peers.

Alternative

Need:

Joey needs to tactually follow braille as a book is read to him.

Supports/services:

Joey requires books on audio tape
Joey's parents must schedule time to read to him at home.
Joey must access services of the CNIB and the itinerant teacher for the visually impaired.
Joey's family must be provided with twin vision (braille and print) books.

Difficulty: Outcomes lack context and fragment the learning

Example: Henry

Outcome: Henry will complete thirty 2-digit addition equations with 90% accuracy.

The problem:

While addition is an important aspect of some childrens' programs and while it is an important skill, it is important only insofar as it enables one to solve real world problems. Henry is fourteen and has been struggling with mathematics for several years. It might be more authentic and relevant for Henry if he were to learn addition because it enabled him to find the answer to a problem which he *wanted* to solve. The real outcome for Henry is problem solving.

Alternative outcome:

Henry will use a calculator to solve addition problems involving the amount of lumber needed to construct a project.

Difficulty: Several outcomes written as one

Example: Craig

Outcome: Craig will identify potentially frustrating situations, mentally repeat his problem solving steps when in such situations, and inform an adult if he needs a place to cool down.

The problem:

There are at least three things that Craig has to do here. If Craig actually needs to work on each of these components and if they will be evaluated separately, then each one should be a separate outcome. This will help Craig feel a sense of accomplishment and will help his parents and caregivers to focus their efforts on one aspect of Craig's strategy at a time. The three components may be sequential and may indeed be taught in a unified way, but should be identified as separate outcomes for the **ISSP.**

Alternative outcomes:

Craig will identify potentially frustrating situations.
Craig will mentally repeat his problem solving steps when in a frustrating situation.
Craig will inform an adult if he needs a place to cool down.

Difficulty: Outcomes overly prescriptive

Example: Terry

Outcome: Using a 10 cm foam ball tossed at him from a distance of 3 meters, increasing to a distance of 7 meters, Terry will catch the ball by grasping it using two hands, with 90% success.

The problem:

Sometimes a high degree of specificity and accuracy is important, especially if the skill involves potential danger or risk to oneself or another. While there are situations where being very prescriptive is important, there are many situations where being overly prescriptive in the outcome can restrict the practitioner and can cause the instruction/intervention to become very rigid and meaningless. Care needs to be taken that the degree of prescription is not over-done wherever possible and that the creativity of the teacher/practitioner is not stymied unnecessarily.

Alternative outcome:

Terry will catch a ball with two hands thrown to him from increasing distances.

How can you make ISSPs manageable and effective?

Often the struggle with ISSPs is how to keep manageable records which are not overly time-consuming and which are useful teaching and planning tools. There are no easy answers for how to do this. Some tips may be helpful:

- **Involve the child and parent**

  Involve children wherever possible in deciding on some of their own goals and objectives (outcomes) and in their own record keeping, thus engaging them personally in their own progress and winning their commitment. Involving parents as equal partners through the process facilitates continuity at home. Informal record-keeping sheets or checklists for the child to use, or a home-school diary might be helpful.

- **Develop the ISSP format locally**

  The more local the process, the higher the degree of ownership. Districts may decide that individual regions can develop their own formats, in which case this should be a collaborative exercise involving professionals from all agencies such as a social worker, a nurse, a psychologist and a physiotherapist. While some of these may not be available onsite in all communities, consultation with them can occur.

- **Find an easy-to-use format**

  Ensure that the format is quick and easy to complete, yet comprehensive enough to include all of the necessary components.

- **Involve, in the writing of the ISSP, the individual(s) who will be most involved in implementing it**

  It is not realistic to expect someone to make decisions regarding how a plan will be implemented in someone else's environment, nor is it realistic to exclude from the process the very person who will have much of the responsibility of carrying it out. Professionals need to work together to ensure that the plan developed is workable in their environment and that they can be committed to it.

- **Write accurate statements which are clear and jargon free**

  The **ISSP** should contain only language that is clear. Overly negative language is usually not productive. Also, vague and "fuzzy" statements are not helpful. The **ISSP** should contain language which accurately describes the child's needs and the plan of action.

- **Be succinct**

  The **ISSP** is not a daily responsibility/lesson plan. It does not need to contain every detail on what you will do with the child but it identifies those aspects of the program/curriculum that are modified/adapted as well as the support services to be provided.

- **Be realistic about how much can be done**

  Don't write an **ISSP** that will take years to complete. The **maximum** projection for goals should be one year. You will be reviewing and revising the **ISSP** twice yearly so the smaller steps can be written to cover from one review date to the next.

References

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Appendices

Appendix A

Potential Support Services Planning Team Members

Potential support services planning team members

The following are sample role descriptions for people who could contribute or be members of the support services planning team. The list is not all encompassing nor is it meant to restrict the kinds of participation which may occur. Some roles are described in more detail than others, since the possible contribution of certain individuals, who may not have traditionally been part of the support services planning process, may not be well known.

Addictions Counselor, Addictions Services

- Coordinates alcohol, drugs and gambling education
- Coordinates prevention, treatment and referral services
- Prepares and provides educational and training programs that meet the needs of various community and professional groups
- Provides information, resources and consultation to various professionals and agencies
- Provides assessment, treatment and aftercare services to individuals and/or their families who have been impacted by alcohol, drugs and/or gambling problems
- Provides an intensive 21 day provincial impatient treatment program
- Promotes a holistic, effective and efficient approaches to addictions by demonstrating leadership and stimulating cooperation and coordination between agencies and individuals offering prevention, treatment or rehabilitative services

Audiologist

- Conducts specific assessments and subsequent diagnosis to identify children/youth with hearing loss or auditory processing problems following a referral
- Provides appropriate counseling, follow-up tests, and rehabilitation (including the fitting of appropriate amplification devices) when necessary
- Participates as a member of the support services planning team when appropriate
- Provides consultation and advice to parents, teachers and other professionals
- Closely linked with Itinerant Teachers for the Hearing Impaired for those "hard of hearing" students who have been fitted with amplification
- Refers to other professionals when appropriate
- Offers inservices, often in conjunction with other related professionals, such as representatives from the School for the Deaf or itinerant teachers, etc.

regarding hearing, cases of hearing loss, types of hearing loss, amplification, communication and classroom management strategies for the hearing impaired and students with auditory processing problems, etc.

Behavior Management Specialist (of the Community Behavioral Services Program)

- Operated by the Community Behavioral Services Program through the Department of Human Resources and Employment
- Offers a community-based behavioral support and training program serving children and adults with a developmental disability and an accompanying intellectual impairment, as outlined by the American Association on Mental Retardation (1992), who exhibit significant behavioral concerns
- Behavioral Management Specialist's (BMS) training focuses on behavioral and developmental psychology
- The BMS offers support and training to families in the home setting
- Can provide consultation around behavioral interventions in the classroom setting with parental permission
- Can provide consistency in application of interventions between the school and home environment, with parental permission
- Will receive referrals from the teacher for service, providing parents are in agreement with the referral
- The BMS would not participate in the actual implementation of interventions but may participate and provide technical support and assistance as school personnel design and implement programs in a school setting

Child Management Specialist (of the Direct Home Services Program)

- Operated by the Direct Home Services Program through the Department of Human Resources and Employment
- Provides service to families where one or more of their children, aged 0 to 5 years are considered to be at risk or demonstrate significant developmental delay in any one of the areas of: learning ability, language, physical, social or self-help skills
- Provides early and consistent developmental and family supportive services
- Receives referrals from anyone provided the family supports the referral
- Assists with the transition from home-based intervention to school programs
- With the family's permission, shares current information regarding the child's

level of skill in five areas: physical, self-help, social, academic and communication
- Provides written reports, visits schools and attends support service planning team meetings to share information

Classroom/Subject Teacher

- Collects and keeps records of data relating to the child's strengths and needs through observation and formal/informal assessment
- Collaborates with colleagues and liaises with parents regarding assessment and strategies to meet the child's need prior to referral to the support services planning team
- Implements and keeps records of the results of specific instructional strategies targeted to meet the child's needs at the pre-referral stage
- May be involved in making a referral to the support services planning team where warranted
- Presents data concerning the child's strengths and needs at the supports services planning team meeting or supplies a written or oral report to another representative
- Assists in writing the teaching component of the **ISSP** for those areas where he/she has responsibility for implementation
- Implements those portions of the **ISSP** for which s/he has been designated responsibility
- Monitors and records the child's/youth's progress

Coordinator of Student Support Services

- Provides consultation on assessment for children with exceptionalities
- Provides consultation and advice on programming and instructional issues
- Can assist with procedures for documenting children under specific provincial funding categories
- May assist in accessing/providing; professional development, materials and/or resources in specific areas of exceptionality

Dietitian

- Assesses nutritional status
- Develops nutritional care plan
- Educates children, family members and caregivers of the needed changes to

nutritional status
- Evaluates individualized care plan objectives through follow-up
- Adjusts care plan as necessary
- Receives referrals on children who may be underweight, overweight, have bowel problems, have feeding problems, have poor eating habits, or children who may need adjustment of tube feeding products or schedule

Guidance Counselor

- Provides informal consultation and support to teachers during the pre-referral stage on emotional, behavioral, personal, social, guidance, career and transition related issues
- Conducts individualized assessments (including career/vocational assessment) as part of the support services planning process, ensuring that assessment information is current
- Presents data on the child's strengths and needs at the support services planning team meeting or provides a written or oral report to a representative
- Advises the support services planning team on behavioral approaches, social/emotional/personal/behavioral programming, transitional strategies and supports, and community services which may be accessed by the child/youth
- Assists in writing any component of the **ISSP** for which he/she has been assigned responsibility for implementation
- Provides advice, resources and/or support to others involved in writing the **ISSP**
- Provides specific individual counseling to the child in the educational, career and personal/social areas as designated by the **ISSP**
- Provides direct behavioral programming as designated by the **ISSP**
- Implements all portions of the **ISSP** for which he/she has been designated responsible
- Monitors and records the child's/youth's progress

Itinerant Teacher for the Hearing Impaired

- Provides instructional support to children/youth with hearing impairments
- Ensures access to specialized equipment and materials to support children/youth who are hard of hearing
- In conjunction with parents and other personnel, provides assessment of progress of children/youth who are hard of hearing children through a formal and consistent assessment program, supplemented by informal observation

- Consults with school personnel, provides advice and guidance to teachers who have hard of hearing children in their classes, secondary to the provision of direct services to their children
- Participates in placement decisions in consultation with the support services planning team
- Consults with parents, providing information, advice and guidance where required
- In conjunction with the ISSP team, develops the schedule of delivery of support services to eligible children/youth
- Develops appropriate programs and designs support services as part of the support services planning team
- In conjunction with the principal, identifies the services required by the hard of hearing child/youth and ensures delivery with appropriate support agencies (e.g., ENT, Audiology, Speech Pathology, School for the Deaf, Assessment Team, Communication Disorders Clinic, etc.)

Itinerant Teacher for the Visually Impaired

- Assesses visual functioning
- Recommends any child/youth suspected of having a vision problem to be checked by an ophthalmologist, and ensures that any child with a known visual impairment is seen regularly by an ophthalmologist
- Ensures that the child/youth, parents and team members understand the educational implications of that child's specific eye condition and acuity
- Provides consultation and advice regarding instructional strategies, appropriate teaching techniques and environmental adaptations for children/youth with visual impairments

- Is involved in the development of individual support services plans
- Arranges for the provision of appropriate vision-specific teaching aids, specialized equipment and materials
- Develops, coordinates and monitors programs that can be implemented and carried out by the child's/youth's caregivers
- Provides direct instruction to the child/youth, in cooperation with the team members , when the difficulty experienced is a direct result of visual impairment, and as outlined in the ISSP
- Teaches compensatory skills (e.g., braille, use of low vision aids, visual efficiency, listening skills, typing)

- Transcribes braille when necessary

Nurse, Community Health

- Provides information regarding health issues and appropriate community resources
- Provides information to children/youth and caregivers about health/handicapping conditions
- Assists with the health component of child's ISSP
- Assists with interpretation of health implications on the child's/youth's development and education
- Participates in developing/providing safety/injury prevention programs
- Assists children/youth and their families in accessing required health services
- Provides information, inservice education, expertise and resource materials to assist the other professionals
- Provides formal presentations on health issues to children/youth, parent groups and school board personnel
- Assesses child's/youth's health in order to provide appropriate interventions
- Provides immunizations and screens for hearing and vision problems
- Helps child/youth and his/her family become aware of issues which affect their health, and the development of needed resources
- Liaises with other agencies and systems to facilitate coordinated care for children/youth and families
- Refers to appropriate agencies and organizations
- Participates in community development and community programming to increase awareness of public health issues

Nurse, Psychiatric and Mental Health (Community)

- Conducts comprehensive holistic assessments for individuals and families that address physical, emotional, behavioral, cognitive, social, cultural and spiritual components
- Makes nursing diagnosis and provides preventative, promotive, supportive, rehabilitative and curative interventions to individuals, groups and families
- Liaises with other agencies and systems to facilitate coordinated care for children/youth and families
- Monitors and evaluates the effect of interventions and revises, in collaboration with the child/family and other team members, the plan of care as required
- Provides follow-up and aftercare to clients discharged from inpatient services

- Participates in community development and community educational programs to increase mental health awareness

Nurse, Secure Custody Services

- Works at Newfoundland and Labrador Youth Centre and Pleasantville Youth Centre, Department of Justice, as a member of the interdisciplinary team providing care and safety to youth in residential secure custody
- Responsible to provide a full range of nursing services, including nursing diagnosis and preventative, supportive, rehabilitative, and curative interventions to residents
- Monitors and participates in the plan of care, with other members of the team, family, and other professionals
- Coordinates the delivery of in-house contracted medical services
- Liaises with community health care officials for the procurement of other necessary health services
- Provides direct counseling in substance addiction and adolescent sexual deviance
- Conducts research, participates in various committees, identifies and addresses staff training needs and program deficiencies

Occupational Therapist

- Provides assessment, consultation and intervention
- Improves functional status
- Translates individual skills into function

- Teaches compensatory skills
- Selects adaptive equipment and trains in its use (e.g., computers, seating and positioning devices, wheelchairs, school chairs, side-lyers)
- Provides advice on modifications to home and school environments (e.g., bathroom equipment, desk height adaptations, etc.)

in areas of:

- fine/gross/sensory motor functioning (including prehension, grasp, handwriting/written output, movement, balance coordination, proprioception, kinesthesia)
- activities of daily living (including environmental accessibility, eating and drinking, toileting, personal hygiene, dressing, operation of communication devices, transfers, wheelchair mobility, etc.)

- transition planning (including work, independent living, community access)
- perception (including motor planning, visual-motor, visual-spatial, visual-tracking)
- psycho social functioning (including self-esteem, social skills, assertiveness training, anger management, goal setting, coping/stress management techniques)

Parents/Guardians

- Liaise with the professional during the pre-referral stage, where applicable
- May be involved in making a referral to the support services planning team
- Share information regarding their child's strengths, needs and interests, relevant background information as well as their own wishes for their child at the support services planning team meeting
- Are full partners in the decision-making processes at support services planning team meetings
- Provide consent/acknowledgment as required for assessment, service provision, programming, etc.
- Are involved in assisting with the writing of any component of the **ISSP** in areas for which they have responsibility for implementation
- Implement those portions of the **ISSP** for which they have been designated responsibility
- Monitor the child's overall progress

Physician

All physicians who provide services to children and youth from birth to school leaving have valuable information and provide services which are necessary for their health, well-being and growth and development.

Physician, including general practitioners, pediatricians, developmental pediatricians, ontologists, ear/nose/throat specialists, opthamologists:

- Conduct assessments, offer diagnoses and provide treatment to any child (and family) who experience an illness or significant health problem within their area of expertise
- Arrange and/or provide required medical interventions including admissions to hospital
- Arrange referrals to colleagues and allied health professionals
- Provide consultative services to other professionals involved/providing

services to the child/youth
- Participate in discharge planning for children/youth under their care and ensures appropriate follow-up

Physiotherapist

- Prevents deformity and maintains/develops gross motor function to maximal levels within limits of physical potential
- Deals with movement, ambulation and positioning, in school
- Recommends specific devices (e.g., standing braces, ankle splints, crutches, walkers, wheelchairs, school chairs, side-lyers)
- Assessments and interventions in the areas of:
  - gross motor: balance, incoordination, decreased mobility, abnormal walking patterns, jumping/throwing/kicking skills
  - muscle tone: increased or decreased due to neurological problems
  - muscle strength: lack or, or weak movements, decreased range of motion
  - joint integrity: inflammatory joint problems, joint range, contractures - deformities
  - posture: sitting and standing postures, kyphosis, scoliosis, lordosis
  - sensory problems: loss of sensation due to neurological problems, proprioceptive kinaesthetic problems

Principal/Vice Principal, Secure Custody Services

- Ensures the participation of faculty teachers and instructors in the resident case planning process
- Provides administrative and professional support to teachers and instructors in the development of Individualized Educations Plans and the integration of the IEP's with the overall case planning process
- Ensures the delivery of a facility based education program ranging from Kindergarten to Level III, adult education, and work experience; coordinates post secondary education placements
- Coordinates the in-house academic program to resources in the community and ensure that facility instruction is compatible to community resources to facilitate the resident's return to school/alternate programs after release
- Lobbies and collaborates with the School Boards for the reintegration of residents to the regular school system and shares resources with School Boards and other educational facilities, where appropriate

Psychiatrist, Child and Adolescent

- Conducts psychiatric and other assessments, diagnoses and provides treatment to any child (and family) who experiences a psychiatric illness or significant mental health problem
- Arranges and/or provides required medical interventions including admission to hospital
- Provides consultative phone services to general practitioners, school personnel, social workers, nurses, psychologists, daycare workers, parents and others regarding children/youth receiving psychiatric services
- Participates in discharge planning for all clients/families and ensures appropriate follow-up

Psychiatrist (Contracted) Secure Custody Services

- Conducts psychiatric and other assessments, diagnoses, and provides treatment to any resident who experiences a psychiatric illness or significant mental health problem
- Arranges and/or provides required medical interventions including admission to hospital
- Provides consultation to facility personnel, including nurse, social worker, youth care worker, psychologist regarding a resident's plan of care and specialized interventions where necessary
- May provide specialized interventions for/on behalf of staff, where consent is given, and where appropriate to enhance and facilitate optimal work performance
- May deliver staff inservicing, when requested

Psychological Assistant

- Conducts psychological and other assessments such as personality, IQ, learning style and neuropsychological
- Provides treatment to individuals that includes the different modalities of therapy
- Provides consultative services to and liaises with other agencies and individuals
- Develops and evaluates programs for clients and families

Psychologist, Clinical

- Conducts psychological and other assessments such as personality, I.Q., developmental and neuropsychological assessments and makes appropriate diagnosis
- Provides treatment primarily to individuals (but not limited to) that includes psychotherapy, cognitive behavioral therapy, pain management, relaxation and social skills training and developmental counseling
- Provides consultative services to and liaises with other agencies and individuals
- Provides consultative services to schools regarding children entering the system
- Offers direct intervention with the child and the family
- Develops and evaluates programs for clients and families

Psychologist, Educational

- Provides informal consultation/support to teachers and parents/guardians during the pre-referral stage and more formal consultation/support throughout the support services planning process
- Conducts individualized psychological/psycho educational assessments as part of the support services planning process ensuring that assessment information is current
- Presents data and interprets the results of various assessments at the support services planning team meeting or provides a written or oral report to another member of the team
- Advises the support services planning team on strategies, curriculum, approaches, services and supports required by the child
- Assists in writing any component of the **ISSP** for which s/he has been assigned responsibility for implementation
- Provides advice, resources and/or support to others involved in writing the **ISSP**
- Implements those portions of the **ISSP** for which he/she has been designated responsible
- Monitors and records student progress

Psychologist, Secure Custody Service

- Applies a series of specialized assessments and tests for the development and implementation of therapeutic programs designed to reduce and remediate a variety of emotional, behavioural, learning, developmental, and other problems of residents
- Prepares diagnostic reports and notes on progress; modifies treatments and programs as necessary
- Participates in multi-disciplinary case conferences; advises and consults on resident's progress; facilitates the establishment of realistic short and long term goals
- Conducts staff inservicing and education; develops and maintains liaison with affiliated community
- Provides direct clinical counselling and interventions, including research in a clinical speciality or other specialized area of responsibility/need

Recreation Therapist

- Assists children with exceptionalities to enhance their social, emotional,

intellectual and physical development through leisure/recreational activities
- Helps children develop attitudes toward leisure and skills in various activities that will remain a part of their future lifestyle
- Assesses children's interests and needs in the area of leisure/recreation
- Provides consultation to other team members (e.g., physical education teacher) on appropriate activities, adapted equipment, teaching techniques, disability awareness, information on competitive opportunities (including disability classification for competition)
- Provides support for specialized activities (e.g., skiing) enabling children with disabilities to participate as fully as possible

School Administrator (principal or vice-principal)

- Provides administrative support to teachers and other educators in their efforts to meet the needs of children
- Ensures that appropriate educational personnel form part of the team
- Clarifies the specific responsibilities of school based team members
- Ensures the full implementation of the school component of the support services plan
- Facilitates the use of in-school facilities to conduct support services planning team meetings
- Collaborates with the Individual Support Services Manager to ensure that the equipment, materials and human/material resources committed by Education are accessed
- Collaborates with the Individual Support Services Manager to ensure that parents are aware of the in-school components of the **ISSP** and that they sign all necessary educational referral/consent forms

(NOTE - Previous policy delineated the role of chair of thesupport services planning team to the principal or vice-principal. This is now part of the role of the Individual Support Services Manager, a role which may be assigned to any member of the support services planning team. If s/he is on the team, the principal or vice-principal may or may not act in the capacity of Individual Support Services Manager.)

Social Work Supervisor, Secure Custody Services

- Employed at the Newfoundland and Labrador Youth Centre, Department of Justice and is responsible for professional social work supervision, social work program management, and consultation for the case management team
- Negotiates and administers contractual services for the delivery of specialized

treatment programs
- Has direct involvement in case assessment, case planning and management
- Delivers individual and group counseling/treatment programs
- Takes a lead role in functioning of interdisciplinary teams involved in the implementation and evaluation of individual programs for all residents

Social Worker, Child Welfare

- Mandated by the Child Welfare Act to intervene in situations where it is felt that a child under the age of 16 may be in need of protection as defined by the Act
- Operates under the auspices of the Department of Human Resources and Employment
- Referrals come from a variety of sources including self-referrals by family, other professionals such as educators and mental health professionals, and from the community at large
- Social worker's initial involvement is primarily in the area of completing an initial assessment with the family to determine whether in fact the children have been or are at risk of maltreatment
- If the outcome of the initial assessment reveals that a child is in need of protection, the social worker will then engage the family in a comprehensive assessment of risk which identifies the risk factors and family strengths and an associated case plan which addresses these issues
- Where two or more services may be involved, the social worker and family may initiate a support services planning team meeting
- In circumstances where individual support services plans are being developed for children who are in the care of the Director of Child Welfare, social workers acting as the legal guardian of the child will participate in the planning
- In all other circumstances, the child protection social worker would not participate in individual support services planning without the parents consent

Social Worker, Family and Rehabilitative Services

- Advocates with the school or the community on behalf of the child with the disability and his/her family, to ensure that concrete instrumental supports and aids are provided to enable the child to succeed to the best of his/her ability
- Assesses the interaction between problems and needs of the child with the disability and the impact on educational supports and school performance
- Consults with school personnel on the special needs, social development,

emotional and sexual development of the child with a disability
- Mediates in the interest of increased awareness and consciousness raising for school personnel and fellow students in an effort to decrease potential bias (e.g., treating a child with a physical disability as if s/he is developmentally delayed)
- Provides periodic crisis intervention for the child and his/her family in situations where the crisis impacts other children, teachers and school personnel
- Provides and promotes early detection and early intervention of potential problem areas that may be directly related to the disability, and impacting school performance
- Counsels the child and family drawing from a rehabilitative knowledge base and perspective

Social Worker, Mental Health

- Conducts biopsychosocial assessments with emphasis on family functioning and dynamics and identifies actual and potential problems
- Provides a range of therapies to individuals, couples, families and groups including but not limited to adjustment counseling, resource counseling and psychotherapy
- Advocates for clients and families and provides leadership in the area of community development and consumer involvement in issues related to mental health
- Participates in discharge planning and makes appropriate referrals
- Provides a systemic view and ecological perspective on clients and family situations.

Social Worker, Secure Custody Services

- Employed at the Newfoundland and Labrador Youth Centre and the Pleasantville Youth Centre, Department of Justice
- Operates under the legislative authority of the Young Offenders Act (Canada) and Young Person's Offense Act (NF)
- Provides a range of professional social work services to residents of the youth centre, including case assessment, counseling, development of case plans with other facility staff, the young person, and the family, advocates on behalf of residents and the faculty for needed programs and services

- Completes assessment of young person's needs and progress and submits same to the Youth Court as PDR or progress report
- Provides direct crises intervention and collaborates with and coordinates other services, eg., psychiatric, medical, psychological
- Collaborates with community staff on the plan of care while youth is in custody and facilitates the youth's release plan

Social Worker, Youth Corrections

- Mandated under the auspices of the Department of Human Resources and Employment to provide services to young persons who come into conflict with the law between their 12th and 18th birthdays
- Operates under the legislative authority of the Young Offenders Act (Canada) and the Young Persons Offences Act (NF)
- Referrals usually originate from Youth Court, although informal voluntary referrals may be accepted from youth, parents, or other sources
- Provides assessments of young person's needs to the Court, in the form of Pre-disposition and other formal reports
- Responsible for the delivery of services related to most dispositions (sentences) given by Youth Court, including Probation, Community Service Orders, and Open Custody (Secure Custody and Remand services are the responsibility of the Department of Justice)
- May be involved in Alternative Measures Programs, and other community-based preventative strategies
- Conducts assessments of needs of young persons and their families, and may collaborate with other agencies in this process
- Completes plans of intervention, in conjunction with the youth, parents, and other professionals or agencies, including school authorities
- Provides individuals and family counseling, advocacy for services, crisis intervention, etc.
- Will be involved in Individual Support Services Planning where the youth is formally referred from Youth Court, or is voluntarily in receipt of services
- Implements those portions of the **ISSP** for which s/he has been designated responsibility

Special Education Teacher (Regular/Resource or Challenging Needs)

- Collaborates with the classroom/subject teacher regarding pre-referral monitoring of children, referral to the support services planning team, writing

portions of the **ISSP** and implementation
- Provides consultation regarding assessment, instructional strategies and curriculum differentiation for children with exceptionalities
- Completes individualized educational assessments for children with exceptionalities
- May be involved in making a referral to the support services planning team, where necessary
- Shares data concerning the child's strengths and needs at the support services planning team meeting
- Facilitates the collaborative efforts of those teachers involved in writing of the teaching component of the **ISSP**
- Implements those portions of the **ISSP** for which s/he has been designated responsibility
- Monitors and records student progress

Speech Language Pathologist

- Identifies children/youth with communication problems following a referral
- Conducts specific assessment and diagnosis of children's communication problems and their communicative needs; reassesses as necessary
- Participates as a member of the support services planning team
- Provides direct or indirect therapy
- Provides consultation and advice to parents, teachers, and other professionals on speech and/or language related issues
- Refers to other professionals as necessary
- Offers inservice in the areas of: articulation, phonology, fluency, voice, receptive language, expressive language and pragmatics

Student Assistant

- Assists the teacher by contributing information regarding the child's strengths and needs
- May attend support services planning team meetings as required
- Assists the teacher in providing personal care to children including eating and drinking, lifting, self-care and toileting
- Assists with the operation of specialized equipment (e.g., stairtrac, wheelchair, walker)
- Accompanies/porters the child to and from classes and school activities
- Assists the teacher preparing child-specific materials
- Assists with child-specific assistive devices, taking notes, taping lectures and reading
- Assists the teacher during emergency procedures

- Assists the teacher in meeting the child's needs as outlined in the **ISSP**

Teacher/Vocational Instructor, Secure Custody Services

- Responsible to implement an individualized education plan including vocational instruction, for each assigned resident which considers the individual resident case plan
- Participates as an active member of the faculty's multi-disciplinary team in developing the resident's plan of care, intervention and treatment
- Collaborates with community teachers on the resident's prior academic record and maintains community linkages to foster academic reintegration upon release
- Implements and records specific instructional strategies and monitors and records youth's progress while at the facility
- Where a resident's educational needs indicate, facilitates placement into a vocational program/work experience and co-ordinates and monitors resident's progress with the primary service providers
- Participates in staff training; identifies program deficiencies and recommends other needed services

Youth Care Worker, Secure Custody Services

- Assists and participates in the development and implementation of plan of care, security, and safety of residents
- Responsible to observe, supervise, manage, and document the behaviour or young offenders in residential secure custody
- Guides and counsels residents in acceptable behaviour, appropriate daily living and social skills; supervises residents for periods of leisure, study, work; escorts residents for medical and other outside appointments, home visits or temporary release
- Observes and notes any behavioural, medical or psychological/psychiatric disturbances in residents and initiates appropriate remedial action
- Physically intervenes, where appropriate and according to policy guidelines, when presenting behaviour of youth poses an actual or potential threat to the well-being of self, others, property, faculty or is indicative of escape
- Actively participates in staff training and meetings, may be required to attend court and drive faculty vehicles

Appendix B

Problem Solving Process

Problem Solving/Conflict Resolution/Facilitation

1. Ask the individual with the concern to state it as concisely as possible (in less than 5 minutes).

2. Ask each person around the table if they wish to ask **one** question for clarification purposes
   Start with the person on your right and ask him/her if he/she would like to ask a question.
   Let the individual bringing the concern answer the question.
   Do not allow the person asking the question to comment or ask another question until their turn comes around again.

3. Keep moving around the table until all questions have been answered. If the same question(s) start to arise you may wish to stop this phase of the process and move to the next phase.

4. Each person, in turn, is asked to offer one solution (only one). Ask a recorder to write the solutions, as offered, on a flipchart if available (if not a notepad). The individual with the concern cannot comment during this phase.

5. When each person has had a turn offering a potential solution or when options run out (you may have to move around the group more than once), ask the individual bringing the concern to say:

   3 - if a solution could be implemented immediately; or
   2 - if he/she would like more information; or
   1 - if they have already tried the solution or it is not feasible at this time.

   as you reread the proposed solutions

6. Ask the individual bringing the concern to implement all 3s or seek help of named persons in group to learn more about the 2s.

7. Thank everyone for their participation, make sure the recorder notes the problem and the resolution and continue with the meeting.

Appendix C

Sample Common Forms of

All Individual Support Services Plans

TEAM MEMBER CONTRIBUTION

To be completed after an assessment/observation and to be brought to the ISSP Team meeting, or forwarded to the Manager if member is unable to attend. This sheet may be retained by each team member in his/her own file on child/youth.

CHILD/YOUTH _____

STRENGTHS	*NEEDS*

INDIVIDUAL SUPPORT SERVICES PLAN
TEAM MEMBERSHIP

NAME OF CHILD_____ DATE OF BIRTH_____

ADDRESS_____

COMMUNITY_____ REGION_____

SCHOOL_____ SCHOOL DISTRICT_____

TEL. NO._____ ISSP MANAGER_____

DATE TEAM ESTABLISHED_____ DATE OF TEAM MEETING_____

NAME	PHONE/FAX	AGENCY/ADDRESS
NOTE: NAME OF ISSP MANAGER SHOULD APPEAR IN THE LIST		

INDIVIDUAL SUPPORT SERVICES PLAN

(Strengths & Needs Agreed by Consensus of Team)

Child/Youth _____

STRENGTHS	NEEDS

(Goals agreed by Consensus of Team)

Child/Youth_____

Goals	To be implemented by	Environment(s)	Date of review

INDIVIDUAL SUPPORT SERVICES PLAN
SERVICE NEEDS

Child/Youth_____

Service Area	Description of Service Needs and Preferred Service Options	Is service available (Yes or No)	Who will be responsible for obtaining service	Person/Agency Responsible for Implementation	Date Service Obtained	Review Date

Areas for discussion could include and are not limited to: place of residence, (location and support needed); social; emotional; developmental; supportive services; health needs (physical needs, medications, procedures); equipment (personal, adaptive); materials and supplies; facilities; behavior; transportation; financial; family; vocational and career planning; recreation/co-curricular.

INDIVIDUAL SUPPORT SERVICES PLAN SUMMARY

Comments:

Signature:

Parent

Child (if participant)

Position

Position

Position

Position

Position

INDIVIDUAL SUPPORT SERVICES PLAN
MANAGER'S RECORD

Individual Support Services Managers will contact members on actual review date and make appropriate notations.

Goal/Service Area	Date

Information for Parents/Guardian
Informed Consent

Children/youth and families may receive services from many agencies and service providers to meet their needs. To ensure that your child's needs are met, service providers will work together with you to develop an Individual Support Services Plan (ISSP). In order to develop an effective support services plan, information about your child will be shared. You will be asked to sign a consent form to permit information sharing. This will allow the support services team to discuss strengths and needs, coordinate service delivery and monitor services to ensure that your child's needs are met.

Before you sign this form you should know:

- You have a right to participate in the ISSP process.
- You have the right to privacy.
- If you consent to the sharing of information, your consent must be informed (the person asking you to sign the form will explain the purpose of sharing information).
- You have the right to know what information is to be shared and how the information is to be used.
- You can decide what information will be shared with whom, for what purpose, and to what benefit.
- Only relevant information about your child's strengths and needs will be shared for the purpose of developing the ISSP.
- You have a right to refuse consent.
- Information will not be shared without your consent, unless the life, safety or well-being of your child or others is at risk.
- You have the right to ask questions before you give consent.
- If you sign this consent form, information about your child's/youth's needs will be entered into a data base to be used for regional and provincial service planning and for the development of regional/provincial service profiles. This data will be kept confidential. Information will be shared with service providers only on a need-to-know basis to assist with meeting the needs of your child.

CONSENT -- RELEASE OF INFORMATION

I, _____ declare that I am: [*please check appropriate box*]
(Name of consenting party)

☐ the parent/legal guardian of _____ Who was born on the ____day of _____, 19___; or

☐ I am a minor child, born on the _____ day of _____, 19 ____, who is 16 years of age or older and who has withdrawn from parental control; or

☐ I am 19 years of age or older.

I HEREBY GIVE MY PERMISSION to (a) representative(s) of:

___ the Department of Health and Community Services
___ the Department of Justice
___ the Department of Human Resources and Employment
___ the Department of Education
___ Other (please specify) _____

to: ____ Release/share relevant information with members of the ISSP Team
____ Release to _____ (Others - please specify), the following information _____

_____ (Describe information)

____ Obtain from _____ (Identify Department or agency)

the following information _____ (Describe information - be specific)

____ Complete Child/Youth Profile

which is necessary for the development/implementation of the individual support services plan.

I understand that the information which is the subject of my consent shall be treated as confidential and will only be shared to the extent necessary to develop and/or implement the individual support services plan. This information will only be disclosed in accordance with federal/provincial laws and will not be shared with any other person or agency without my consent except in accordance with such laws and with any interdepartmental protocols on the sharing of information.

This consent is given of my own free will and shall be valid for _____ (Period of time) unless withdrawn by me in writing.

_____ **DATE**

_____ **SIGNATURE OF CONSENTING PARTY**

_____

_____ **WITNESS**

WAIVER OF CONSENT

I, _____ declare that I am employed by_____ .
(Name of party) (Identify dept. or agency)

I met with _____ on _____ for the purpose of
(Identify individual) (Date)

obtaining a consent to the sharing of information for purposes of the individual support services planning process.

It is my assessment that _____ is incapable of appreciating the nature
(Identify individual)

and consequences of the required consent for the following reasons: _____

_____

_____

I therefore seek approval for the waiver of consent.

_____ _____

DATE SIGNATURE

.....

Approval is hereby given for the waiver of consent to enable information to be shared for the purposes of the individual support services planning process

_____

SIGNATURE OF SUPERVISOR

Appendix D

The
Support Services Planning Process
for Children/Youth
with Special Needs
in Newfoundland & Labrador

Screening and Identification

What happens at this stage?	Who is involved?
the parents, significant other professional begins to recognize that there is a problem/concern • general approaches are not sufficient for the child/youth, or • a developmental/learning need is brought to the professional's attention, or • screening procedures, if used, reveal a need the professional realizes that specifically targeted action is necessary the professional begins to learn more about the problem the professional begins to record relevant information and observations about the child's/youth's need	the child/youth • provides information on area of need where possible, through interviews and discussion the professional • defines and clarifies the child's/youth's need • makes relevant others aware of the area(s) of need the parent/significant other • assists the professional to clarify the problem(s) other service providers (eg, education, health, human resources and employment, justice personnel) as needed • provide relevant information • provide consultation to help clarify the area(s) of need

Exploration of Strategies

What happens at this step?	Who is involved?
the professional begins to target specific strategies to meet the child's/youth's need the professional may enlist the support of his/her colleagues through a collaborative problem solving process* the child/youth continues with his/her normal routine further information on the child/youth and the plan for specific strategies is added to the professional's file	the child/youth • provides feedback, where possible, on the strategies the professional • systematically explores specific strategies • updates records on the child/youth • maintains contact with the parent and other relevant individuals the parent • contributes relevant information • collaborates with and supports the professional's efforts other service providers as needed • provide advice and consultation to help clarify the problem • brainstorm possible strategies • consult on possible adaptations

* see Teachers Helping Teachers Problem Solving Teams That Work, (1994), North York, ON: The Roeher Institute. The video and handbook are available on loan from the Department of Education Learning Resources Distribution Centre.

Ongoing Evaluation and Monitoring

What happens at this step?	Who is involved?
the professional evaluates and monitors the success of the strategies if the strategies are successful, then the process may terminate here if the strategies are not immediately successful, the professional may decide to give them more time to work if the strategies continue to be unhelpful, advance to the next step and refer to the support services planning team	the professional • evaluates and monitors strategies • systematically tries new strategies from those brainstormed at the screening stage • continues to add to records as new information becomes available • maintains interaction with the parent and the child/youth (unless compelling reasons exist) regarding progress

Referral to Support Services Planning Team

What happens at this step?	Who is involved?
the professional • ensures all reasonable pre-referral efforts have been made • ensures record keeping on the child/ youth is as well developed as possible including information on the child's needs and on the strategies tried • completes referral form(s) - internal and external - depending on what's needed • communicates with program supervisors	the professional • refers the child if the pre-referral activities have been completed without the desired results • discusses the referral procedure and ISSP process with the parents and ensures they are comfortable with the process, demonstrating understanding of their role the parent • may be involved in initiating referral to the support services planning team Individual Support Services (ISS) Manager • liaises with caregiver and/or personnel to initiate the support services planning team meeting

Support Services Planning Team Meeting

What happens at this step?	Who is involved?
the professional (if no ISS Manager exists) or the ISS Manager (if one exists) calls together relevant persons for the team meeting the team elects a ISS Manager, (if one does not exist) who chairs future meetings, a secretary, who keeps minutes, and any other functions the team needs the team uses a process to assist the recorder to document the child's/youth's strengths and needs based on the child's/youth's records, the contribution of other team members, and any new assessment information (the team may decide to refer for further assessment); service areas; goals the team goes through a problem solving process to arrive at the final plan for the child/youth (ISSP) responsibility areas are set the date for the next review meeting is set members sign the ISSP	core members of the team are • the parent • the child (except for compelling reasons) • ISS Manager (if one is in place)

Support Services Plan Developed

What happens at this stage?	Who is involved?
after the meeting, the details re "how" the goals will be accomplished and service areas addressed will be determined by the team members accepting the responsibility(s)	the child • where possible, the child is involved in the development of a self-recording system for his/her own ISSP each professional • further develops the strategies

Implementation of Support Services Plan

What happens at this step?	Who is involved?
each member of the team carries out his/her responsibilities as outlined in the meeting minutes and ISSP the ISS Manager ensures that members comply with their responsibility areas and that resources that have been assigned are acquired	the child/youth • to the extent possible and with the necessary help, maintains his/her own daily program, recording tasks as completed, providing feedback to professionals/caregivers offering support services members of the support services planning team • each one implements those areas for which he/she is responsible, keeping relevant records

Review of Support Services Plan

What happens at this step?	Who is involved?
the ISS Manager calls the team together at the agreed upon review date the team reviews the child's progress (the general outcomes that have been attained) and evaluates the success of the strategies contained in the ISSP the list of child's strengths and needs is revised/refined if necessary the team decides whether to • continue with the ISSP as written **or** • add new goals (general outcomes) to the ISSP **or** • revise the ISSP/change direction **or** • discontinue the ISSP informal meetings are held between individual members of the support services planning team as necessary between formal review meetings	the original members of the support services planning team members may be added or deleted at the ISS Manager's discretion

Appendix E

Checklists to Support the Role Support Services Team Members

CHECKLISTS TO FACILITATE INDIVIDUAL SUPPORT SERVICES PLANNING

Included in this section are the following six checklists:

- Individual Support Services Manager's Checklist: **Before** the Team Meeting
- Supervisory Checklist: **Before** the Individual Support Services Planning Team Meeting
- Individual Support Services Manager Planning Checklist: Transportation: **During** the Individual Support Services Planning Meeting
- Individual Support Services Manager's Checklist: **During** the Individual Support Services Planning Team Meeting
- Document Writing: **After** the Individual Support Services Planning Team Meeting
- Team Members Checklist **Before** the ISSP Meeting
- Team Members Checklist **After** the ISSP Meeting

These are designed to provide detailed information which may be useful during the program support services planning process.

INDIVIDUAL SUPPORT SERVICES TEAM MEETING

INDIVIDUAL SUPPORT SERVICE MANAGER'S CHECKLIST
BEFORE THE SUPPORT SERVICES PLANNING TEAM MEETING

	To Be Done	Completed
1. Check Coordination of Services to Children and Youth, Individual Support Services Plans and relevant Departmental Policies to reference stages in the process	_____	_____
2. Obtain consent for release of information	_____	_____
3. Complete assessment (if appropriate)	_____	_____
4. Read all relevant background information	_____	_____
5. Clarify/validate relevant information with parents and other agencies	_____	_____
6. Ensure that all members		
(I) have been contacted	_____	_____
(ii) know time and place of meeting	_____	_____
(iii) are aware that they should		
- bring/send written supporting document	_____	_____
- be ready to contribute to a discussion of the child's/youth's strengths, needs & goals	_____	_____
7. Clearly articulate a list of strengths and needs gleaned from assessment and questions to be answered	_____	_____
8. Prepare working summary of projected goals, if assessment reports have been received prior to the meeting	_____	_____

INDIVIDUAL SUPPORT SERVICES TEAM MEETING

SUPERVISORY CHECKLIST
BEFORE THE INDIVIDUAL SUPPORT SERVICES TEAM MEETING

	To Be Done	Completed
1. Review the steps in the ISS planning process	_____	_____
2. Consult with personnel to ensure that preparation for ISSP team meeting is on schedule	_____	_____
3. Ensure that environments which children/youth may need to be accessed are realistic e.g., Fire standards, accessibility	_____	_____
4. Consider the appropriateness of environment/space for carrying out procedures such as tioleting, catherization - i.e., privacy, infection control guidelines, sanitation, storage of necessary supplies	_____	_____
5. Ensure that potential staff demands are within the expectations of their roles	_____	_____
6. Consider the resources and support which can actually be made available to this child/youth to ensure success	_____	_____
7. Where appropriate, ensure that transitional planning commences or is in progress	_____	_____
8. Ensure that personnel are prepared to implement the support services plan	_____	_____

INDIVIDUAL SUPPORT SERVICES TEAM MEETING

INDIVIDUAL SUPPORT SERVICES MANAGER CHECKLIST: TRANSPORTATION DURING THE INDIVIDUAL SUPPORT SERVICES PLANNING MEETING

	To Be Done	Completed
1. Transportation addressed at support services planning team meeting	_____	_____
2. Check done re non-disabled siblings being transported to/passing same location	_____	_____
3. Check done re parental ability to provide transportation for child	_____	_____
4. Parents notified of responsibilities re child receiving special transportation	_____	_____
5. Driver informed of responsibilities re child he/she is transporting	_____	_____
6. Vehicle properly equipped - e.g., seat belts, special restraints, etc.	_____	_____
7. Pick up/drop off time established with parents and driver	_____	_____
8. Pick up/drop off place established with parents and driver	_____	_____
9. Routine established with parents re emergency (early) pick up/drop off from school	_____	_____
10. Routine established with driver re emergency (early) pick up/drop off from preschool/school - e.g., weather, closure, sick child	_____	_____
11. Driver provided with "in bus" list of parents' and doctor's telephone numbers for contact in emergency situations	_____	_____

		To Be Done	Completed
12.	Routine established with drivers re emergency situations which might occur during travel - e.g., sick child, vehicle accident	_____	_____
13.	Driver aware of early childhood regulations re driveways and entrances to be used, speed on property, backing up, etc.	_____	_____
14.	Driver aware of regulations re security of wheelchairs, use of seatbelts, etc.	_____	_____
15.	Driver notified of procedure to follow re reporting of medical and conduct problems of child on vehicle	_____	_____
16.	District specific guidelines re transportation considered and followed	_____	_____
17.	Personnel aware of responsibilities re pick up/drop off of children/youth	_____	_____
18.	Skills pertaining to the least restrictive form of transport for the child addressed in the ISSP	_____	_____
19.	Government guidelines followed for the transportation of children/youth with special needs	_____	_____

INDIVIDUAL SUPPORT SERVICES TEAM MEETING

INDIVIDUAL SUPPORT SERVICES MANAGER'S CHECKLIST
DURING THE INDIVIDUAL SUPPORT SERVICES PLANNING TEAM MEETING

	To Be Done	Completed
1. Members who were unable to attend have been sent current reports	_____	_____
2. Each team member has had an opportunity to contribute his/her input	_____	_____
3. The team has reached consensus regarding this child's/youth's strengths and needs	_____	_____
4. Input from all consultants/service providers has been incorporated into the goals of the ISSP	_____	_____
5. Team has reached consensus regarding		
(i) potential goals	_____	_____
(ii) environments	_____	_____
(iii) materials and equipment	_____	_____
6. Team has addressed the issue of transportation	_____	_____
7. All questions have been noted re environmental requirements for procedures such as tioleting, feeding, etc.	_____	_____
8. Decisions have been made regarding acceptability of the ISS plan	_____	_____
9. All questions have been noted and decisions made re who will seek answers	_____	_____
10. Each member is leaving with a clear understanding of his/her future role in ensuring that the child can attain the goals written in the plan	_____	_____
11. Date of the next meeting has been set	_____	_____

INDIVIDUAL SUPPORT SERVICES TEAM MEETING

DOCUMENT WRITING
AFTER THE ISS PLANNING TEAM MEETING

	To Be Done	Completed
1. Pertinent personal child data obtained	_____	_____
2. Important health and safety information documented	_____	_____
3. Child profile developed	_____	_____
4. Current assessment(s) and dates recorded	_____	_____
5. Strengths and needs identified	_____	_____
6. Annual goals determined and prioritized	_____	_____
7. Most enhancing environments determined	_____	_____
8. Transitional planning addressed	_____	_____
9. Transportation addressed	_____	_____
10. Dates for implementation and review noted	_____	_____
11. Names and roles of ISS planning team members recorded	_____	_____
12. Team signatures obtained	_____	_____
13. Parental comments recorded	_____	_____
Where the ISSP process is terminated		
14. Letter written indicating the team has terminated the process	_____	_____

INDIVIDUAL SUPPORT SERVICES TEAM MEETING

_____ TEAM MEMBERS CHECKLIST
BEFORE THE MEETING

	To Be Done	Completed
1. Complete assessment (if appropriate)	_____	_____
2. Read relevant background information	_____	_____
3. Communicate with supervisor (where applicable)	_____	_____
4. Communicate with ISSM (as necessary)	_____	_____
5. Articulate strengths and needs gleaned from assessments (see page 99)	_____	_____
6. Send report, including strengths, needs and areas where services are required, to ISSM where it is not possible to attend meeting	_____	_____
7.	_____	_____
8.	_____	_____

Note: Add other responsibilities as necessary

INDIVIDUAL SUPPORT SERVICES TEAM MEETING

_____TEAM MEMBERS CHECKLIST
AFTER THE MEETING

	To Be Done	Completed
1. Articulate objectives (outcomes) required to meet goals	_____	_____
2. Determine activities required to meet goals	_____	_____
3. Determine materials/equipment required to meet goals	_____	_____
4. Determine whether other persons need to be involved in plan to meet child's or service needs	_____	_____
5. Complete actions required to meet service needs	_____	_____
6. Document actions as per agency/department policies	_____	_____
7. Communicate with team members as agreed	_____	_____
8.	_____	_____
9.	_____	_____

Note: Add other responsibilities as necessary